



*Scenes from
Alumni Day '76*



Yours for the asking...



Five new Practice Management monographs of special interest to the intern, resident and established physician. Written by the professional staff of Healthco. Drop in on us, write or phone and we'll be glad to fill your request.

++ Healthco
Physicians Office
Design & Equipment Center

25 Stuart Street, Boston, MA 02216
(617) 423-6045

This bi-centennial year marks the flowering of a democracy built upon the foundations of a firm educational system. Due superior program helps create still greater strengths for future years. The Council for Advancement and Support of Education honors your fine efforts with an Exceptional Achievement Award.

We cannot help but beam over our receipt of an exceptional achievement award from the Council for the Advancement and Support of Education (CASE) for the Bicentennial Magazine Publishing Program of the Year. We are in the company of ten other exceptional achievers, including Harvard Magazine. The four issues that brought us this award were the March/April, September/October and November/December 1975 HMABs, and the first one of 1976. We were judged on our looks, content, and even how we spent our money (and how much), a most pragmatic category. We thought you would like to share in our good news.

Editor

George S. Richardson '46

Managing Editor

Deborah W. Miller

Assistant Editor

Gwen Frankfeldt

Advertising Agents

H. James Sargent	John Reeves
54 Egmont Street	345 Jaeger Avenue
Brookline, Mass. 02146	Maywood, N.J. 07607
617/277-5831	201/843-4308

Editorial Board

Robert S. Blacklow '59; Robert M. Goldwyn '56; Franz J. Ingelfinger '36; John B. Levine '79; Marshall deG. Ruffin, Jr. '78; Guillermo C. Sanchez '49; J. Gordon Scannell '40; Prentiss B. Taylor, Jr. '77.

Association Officers

Alexander H. Bill '39, president; Thomas B. Quigley '33, president-elect; William V. McDermott '42, past-president; Oglesby Paul '42, vice president; John P. Merrill '42, secretary; Fiorindo A. Simeone '34, treasurer.

Councillors

Edward Atwater '55, Karl F. Austen '54, A. Clifford Barger '43A, E. Langdon Burwell '44, Patricia Come '72, John P. Dixon '62, Grant V. Rodkey '43A, Nina Tolkoff-Rubin '68, Catherine M. Wilfert '62.

Representative to Associated Harvard Alumni

Curtis Prout '41

Director of Alumni Relations

Perry J. Culver '41

Chairman of the Alumni Fund

Carl W. Walter '32

The Harvard Medical Alumni Bulletin is published bi-monthly at 25 Shattuck St., Boston, Mass. 02115. © by the Harvard Medical School Alumni Association. Third class postage paid at Burlington, Vermont

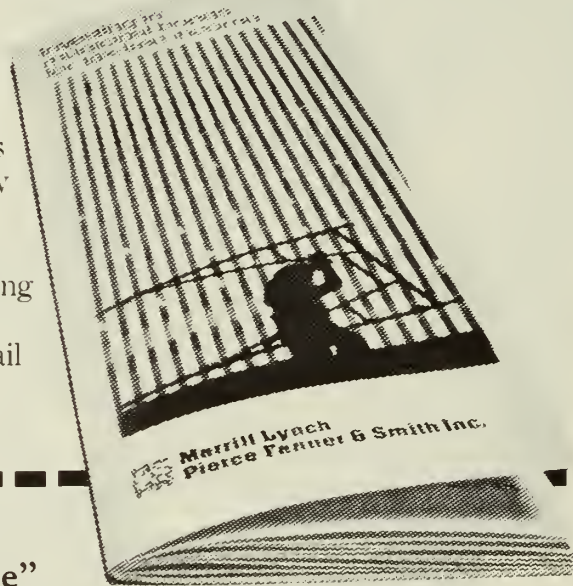
- 3 Overview
- ALUMNI DAY 1976
- 16 Schuss-boom, tra-la!
by Arthur E. Ellison
- 18 Reflections in the wake — two decades of Navy medicine
by Tor Richter
- 20 Those were the days
by Claire M. Stiles
- 23 Margarine and medicine, or butter is bitter
by Howard M. Spiro
- 25 Alumni Survey Committee: Ombudsman of HMS
by William D. Cochran
- 27 A response
by Robert H. Ebert
- 28 Scenes from Alumni Day '76 (cont'd.)
- 29 Reunion Reports
- 35 CLASS DAY 1976
- 36 Valediction
by Robert H. Ebert
- 37 2001 — a 25th reunion odyssey
by Francisko Moreszchki
- 41 Family practice
by Raymond D. Aller
- 42 Our other patients
by Paul S. Appelbaum
- 43 The seven warning signals
by Marvin J. Bittner
- 44 Minorities at HMS: A promise turned sour?
by Fidel Davila, Jr.
- 44 The fifth wheel syndrome
by Samuel Z. Goldhaber
- 45 The role and function of the doctor
by Nils M. Daulaire
- 46 A way of life
by Earnest Wu
- 48 Scenes from Class Day '76
- 49 Letters
- 50 Lost List
- 51 "Retirement" Notes
- 53 Alumni Notes
- 58 Death Notices
- 60 Paul A. Younge

Credits: Cover: David Gunner (center right, bottom left), Deborah Miller; p. 1, 8, 16-25, 28 (top), 35-48, 53, David Gunner; p. 28 (center, bottom), Deborah Miller; p. 29-34, Melvin F. Hookailo; p. 60, courtesy of Mrs. Louise Younge.

How to get tax-free income

This 36-page booklet tells how municipal bonds may increase your after-tax investment income by 60 percent or more, depending on your tax bracket.

It's yours free. Just mail the coupon.



"Investing for Tax-Free Income"

Mail to: Merrill Lynch,
One Beacon Street, Boston, Mass. 02108
Call: 617 725-2506

HMAB

Name.....

Address.....

City..... State..... Zip.....

Home Phone..... Business Phone.....

Merrill Lynch customers, please give name and office address of

Account Executive:.....



Merrill Lynch Pierce Fenner & Smith Inc.

Overview

Davis seen as impugning minority students

Nationwide publicity has been focused on a guest editorial by Bernard Davis '40, the Adele Lehman Professor of Bacterial Physiology, in the May 13 *New England Journal of Medicine* — and on the subsequent censures and rebuttals issued by Dean Ebert and others in the medical community who viewed the article as an attack on medical school recruitment of minority students, both at Harvard and elsewhere.

Dr. Davis's article, entitled "Academic Standards in Medical Schools," was actually a somewhat altered version of a document submitted on January 13 to the Faculty Council for internal discussion, written by Dr. Davis and co-signed by professors Harold Amos, Porter Anderson, David Hubel, Manfred L. Karnovsky, and Fred S. Rosen. The document expressed concern over what it termed the "stretching" of academic standards both in admissions and in the curriculum itself.

Further publicity was given Dr. Davis's views in the May 13 *New York Times* and the May 14 *Harvard Crimson*, in which comments quoted from Dr. Davis further angered his critics.

On May 18, strongly worded statements rebutting Dr. Davis's claims were issued by Medical School Dean Robert H. Ebert, Harvard President Derek C. Bok, and the Faculty Council of Medicine. (Full texts of these, as well as the Davis article, and excerpts from other relevant documents, appear below.) At a rally held by the Third World Medical Students Caucus on the quad-rangle that day, these documents were heard along with condemnatory remarks by Dr. Alvin F. Poussaint, associate dean for student affairs; the Third World Medical Students Caucus; the HMS chapter of the Poor White Health Association and others.

The following day, the heads of the pre-clinical departments and the five co-signers of Dr. Davis's original paper added their voices in support of the minority recruitment program and in affirmation of Harvard Medical School's continued high standards.

Dr. Davis responded to the barrage of criticism first on May 19, in a letter to the editor of the *Crimson* protesting its "slanted" coverage and selective quotation of his remarks; and then on May 21 in a statement of regret for the results of publicity and misinterpretation, and of apology "for my share of these errors."

Dean Ebert wrote to the deans of 118 American medical schools on May 24 and to the editor of the *Crimson* on May 28, and authored a guest editorial in the *New England Journal of Medicine* of June 17, to further counteract the influence of Dr. Davis's statements and cite additional evidence refuting them.

In view of the controversy surrounding the issue, the *Bulletin* staff has thought it best to keep our summary to a minimum and provide our readers with as complete a reproduction of the major original documents as is consistent with space limitations and the avoidance of redundancy.

May 13

"Academic Standards in Medical Schools" by Bernard Davis, M.D. in the *New England Journal of Medicine*:

Since the consumer is particularly blind in purchasing medical care, and his vital interests are often at stake, those who are in a position to screen for aptitude and competence in medicine have a grave moral responsibility. In accepting this responsibility medical faculties have always taken into account qualities of character and motivation as well as scientific ability and knowledge. In addition, in recent years we have finally begun also to take into account long ignored social needs. But no one of these sets of qualifications can compensate for a gross deficiency in another. In particular, as the practice of medicine broadens its scientific base, it increasingly requires a reasonable level of competence in science, at least as long as the M.D. degree leads to an unlimited license to make life-and-death judgments. In this connection preclinical courses serve not only to provide a scientific background for practice but also to screen students for the ability to reason scientifically.

This screening has become more difficult in recent years. A variety of considerations have led medical schools to engage in inno-

vations in admissions, curriculum, grading and criteria for promotion. Some faculties, no longer confident of their ability to maintain adequate minimal standards, have set an external standard by requiring candidates for the diploma to have passed Parts I and II of the National Board Examinations. But for schools that have aimed at leadership this minimal national standard is an extraordinarily low one. Moreover, it has been further lowered in recent years: National Board grades are normalized for each year's population, and so the absolute norm for passing is necessarily lowered by any nationwide increase in admission of students with sub-standard academic qualifications.

It would be a rare person today who would question the value of stretching the criteria for admission, and of trying to make up for earlier educational disadvantages, to help disadvantaged groups. But how far faculties should also stretch the criteria for passing students is another matter. If a board licensing airline pilots allowed extraneous considerations to interfere with objectivity it would be considered criminal. The temptation to award medical diplomas on a charitable basis raises the same question, even though the consequences of fatal error in the two professions are not equally visible and dramatic.

Many faculty members have wondered whether the stretching of standards in their schools in recent years has not exceeded what is reasonable. The problem is illustrated by a distinguished school that recently waived its National Board requirement and awarded a diploma to a student who had been unable to pass Part I in five tries. The award of this degree was virtually inevitable, after five years of investment by the school and the student. But we must look at the erosion of internal standards, and the postponement of decision, that allowed this situation to develop.

Medical faculties can derive deep satisfaction from their success in recruiting and helping many able students from groups that were formerly excluded. But it has also become apparent that patience and sympathy cannot overcome the inability of some students to handle the material. It is cruel to admit students who have a very low probability of measuring up to reasonable standards. It is even crueler to abandon those standards and allow the trusting patients to pay for our irresponsibility.

Considerations of tact, and guilt over our history of enormous racial injustice, have made it difficult to face the problem. But there are dangers in a policy that fails to evaluate the results of our recent experiments objectively. If the public is given a romanticized view we can expect demands for the extension of quotas, rather than demands for strengthening the quality of the product. Thus, recent statements by Senator Edward M. Kennedy (*New York Times* letters to the Editor, March 21 and 31), calling attention to the unequal supply of medical students from different socioeconomic groups, could well be the first step toward quotas for admission from these groups.

It seems time for medical faculties to ask whether we have been properly balancing our obligation to promote social justice with our primary obligation to protect the public

interest, in an area in which the public cannot protect itself.

Excerpts from the *New York Times* article by Lawrence K. Altman, headlined "Professor Contends Medical Schools' Standards Have Dropped Because of Rise in Minority Students":

Academic standards in the nation's medical schools have fallen in recent years because of the rise in the number of admissions of minority students with "substandard academic qualifications," a leading medical educator has charged in a scientific journal. . . .

Dr. Davis's article is one of the rare public statements about academic standards and minority group students, an issue that has generated private criticism from a growing number of teachers in the nation's 115 medical schools. . . .

Faculty members at Harvard and other medical schools have had sharp debates over whether the nation's needs are better served by suddenly increasing the number of black doctors for the black community, even if the standards are lowered, or whether such needs would be better served by a more gradual increase of students with better academic standing.

At the same time, others have debated how many white students with better academic qualifications than the black students should be denied educational opportunities. . . .

Dr. Davis said that he supported the goal of training more doctors from minority groups but that he objected to "widespread public delusion that these programs are going marvelously — they are not, but the public does not know it."

Dr. Davis added that medical school faculty members who are in a position to screen for medical competence have a responsibility "not to give a medical diploma to a person who might leave a swath of unnecessary deaths behind him."

May 14

The *Harvard Crimson* article by Judith Kogan, entitled "Professor Assails Blacks' Performance":

The admission of minority students with what one Harvard Medical School professor calls "substandard academic qualifications" has touched off an internal debate among Med School professors.

Bernard D. Davis '36, professor of Bacterial Physiology, whose controversial opinions appear in an editorial in this month's *New England Journal of Medicine*, said yesterday that gambles Medical schools take in recruiting and graduating unqualified blacks will result in a decrease in the quality of the nation's health care.

The editorial was extracted from a lengthy statement Davis wrote and distributed only to the Med School Faculty Council. The statement was cosigned by five other medical school professors — Drs. Porter Anderson, David Hubel, Manfred Kamovsky,

Fred S. Rosen, and Harold Amos, a black professor.

"Patience and sympathy cannot overcome the inability of some students to handle the material," Davis wrote in the article. Labelling it "cruel" to admit students who have a very low probability of "measuring up to reasonable standards," he said it is even crueler to abandon those standards and have patients pay for our irresponsibility."

Davis said that of the approximately 15 blacks who are admitted each year, virtually every one graduates — including those who, he charged, in the opinion of the faculty "don't deserve the trust that the medical program engenders."

Many of his recent allegations, Davis said, are based on formerly secret information showing that out of 150 Harvard medical students who took the National Med Board examinations last year ten — most of them blacks and Chicanos — failed. In previous years, no more than one or two have failed, and then for emotional reasons, Davis said.

"Any bright student can pass those examinations," Davis said, adding that one student failed five times and still graduated. "I certainly wouldn't trust him as my doctor," he said.

Davis accused Harvard Med School of "passing the buck" and not fulfilling its "moral obligation" to judge which of its students will make competent doctors. "Instead," he said, "when they found, in the late '60s, that it was hard to flunk students, they turned to the national and state licensing boards — much less competent judges — to determine who would become doctors."

Jonathan R. Beckwith '57, professor of Microbiology and Molecular Genetics, disagreed with Davis on the significance of the Boards, and said yesterday that the tests are based on "very particular" knowledge, rather than information that is important in training doctors.

"The medical school standards that Davis claims have dropped are oriented toward producing elite professors and researchers rather than training future doctors to develop sensitivity to people," Beckwith said.

"The medical boards are forcing the medical school curriculum to follow a certain path," Beckwith added. "We try to develop a curriculum where students will have a choice, but if they make this personal choice, they do poorly on boards. The medical school system is a mess."

Prior to the escalation of minority recruitment in 1968, Beckwith said, Harvard had one of the smallest black med school enrollments in the nation. "We had about one-half a black student each year," he said.

Richard C. Lewontin '60, professor of Biology, who has opposed Davis's views in debates on biological determinism, charged yesterday that "this is part of a kick Davis has been on. He thinks blacks are mentally inferior and incompetent because it takes some special ability to be a doctor. Davis argues that these minority students don't have the intrinsic ability to become doctors."

Davis said in a debate with Lewontin last spring that he feels everyone should be judged and treated as an individual, but that blacks do not do as well in general as whites in academic areas.

"Is there any relation between how many patients doctors kill and how well these doctors have done in medical school?" Lewontin asked, calling for research to determine what characteristics make a good doctor.

Edwin J. Furshpan, professor of Neurobiology, who has served on the Med School's admissions committee for several years, said yesterday he is horrified at Davis's recent statements, adding that comments like Davis's endanger the minority admissions program.

"There's a well-established policy at the Med School that the whole person is looked at by the admissions committee," Furshpan said. "Some students with low grades and particular qualities are admitted. In the case of minorities, it is these special qualities that are taken into account."

Furshpan questioned the validity of judging an applicant solely on the basis of his academic record. "We're selecting future physicians, not medical students," he said. "We're looking out for the needs of the country. If the faculty continues to see the need to judge by rigid standards, nothing will change."

The increase of minority medical students in the past seven years has not helped eliminate the shortage of American minority health care, Furshpan said, adding that while minority students may not be the academic "hot-shots" of their medical school classes, one has to take into account a commitment to minority health care and these students' long-term contributions.

"Blacks are entitled to competent physicians," Davis said. "Medical schools can't disregard the question of competence and put out M.D.'s on the basis of ethnic group. We should increase the number of black physicians only in proportion to the number of good applicants that come along."

Frank Eisenberg, a third-year medical school student, said that in terms of what is "relevant to measure," there is no difference between white and minority students in his class.

May 18

At a special meeting of the Faculty Council of Medicine, called on May 17, 1976, to consider the issues presented by an article in the May 13, 1976, issue of the *New England Journal of Medicine* and subsequent news media articles and comments the following resolutions were adopted unanimously:

1. The members of the Faculty of Medicine, acting through their elected Faculty Council, take strong issue with the implications of recent public statements that students not fully qualified to begin their postgraduate training in medicine are awarded the M.D. degree.

The degree of Doctor of Medicine is awarded on satisfactory completion of a stated curriculum. In each case, all of the qualifications of each student to enter medical practice are assessed by a committee appointed for the purpose and presented to the Faculty for its decision and action.

2. The Faculty of Medicine, acting through their elected Faculty Council,

reaffirms its confidence in the admissions policies of the Harvard Medical School and reaffirms its confidence in the quality of the entering student body.

Statement issued by Dean Robert H. Ebert:

Both the faculty and administration are certain that all of the students granted the M.D. degree are highly competent and will make excellent physicians.

I know of no evidence to support the view that the students at the Harvard Medical School have diminished in quality in recent years. Indeed, I would say the standards are as high as they have ever been — perhaps higher.

Dr. Davis, in publishing his article and speaking to the press, speaks only for himself and not for the administration of the Harvard Medical School or the rest of the faculty.

I believe that Dr. Davis's action in identifying an individual is irresponsible, since there was no way of answering the charges without revealing more information on a matter which had been handled internally by the appropriate committees.

In actual fact, the case was a unique one. The student was awarded his M.D. degree only after exceptional proof of his clinical competence. The faculty then voted overwhelmingly to grant him a degree.

Dr. Davis's statement was also irresponsible because of the general implications about the professional acumen of all minority students.

President Derek C. Bok's statement:

I greatly regret the recent publicity casting doubt upon the quality of Harvard Medical School students and their competence to undertake postgraduate training.

On the basis of evidence supplied to me by the dean's office and the registrar, I find no basis for any implication that minority students are less than fully qualified for the M.D. degree in accordance with the normal standards of the Harvard Medical School. On the contrary, the performance of these students in their clinical courses and their success in the internship and residency matching program give me every reason to believe that they will be excellent physicians in the best traditions of the Harvard Medical School.

Excerpts from the speech delivered by Alvin F. Poussaint, M.D., associate dean for student affairs in the Medical School, at the rally organized by the Third World Medical Students Caucus:

We are tired of being smeared. We are tired of being slandered. We are tired of being abused. We are tired of being called names — fed up with implications about our 'inferiority' because of the color of our skin or our ethnic background.

We are sick and tired. Tired of the misguided taking exceptions and trying to make them the rule.

What do we call a person who takes a negative exception about a racial group and tries to make a stereotype of the whole group?

What do we call a man who suggests that most minority group students are incompetent?

What do we call a man who indicts an entire ethnic group, but presents no data? . . .

We who are indicted as substandard must often deal with morally substandard faculty, some men who lack humanity and empathy for the problems of others. What is it to them that minority students, already under great tensions, must enter the wards, the hospitals and clinics, faced by patients, nurses and doctors who will believe them incompetent because of the color of their skin or the sound of their last name?

. . . We are tired of being put on the defensive when in the minds of some people our only chance of restitution is to evaporate, to disappear, or to forever be shut out of the mainstream of the majority.

What crime have we committed? What crime did Martin Luther King commit that the government and the FBI sought to destroy him; to crush him; to stamp out his movement? He committed the crime in America of wanting his people to be free, of wanting equality, of wanting all men to have justice, and he was destroyed.

What crime have we committed? What crime have these students committed, to be slandered, to be spiritually destroyed. They committed the crime of wanting an education, the crime of wanting to work hard to be a doctor, to be a lawyer, the crime of wanting to serve their communities and their people, who are crushed under the weight of racist oppression.

We're tired, and we're sick and tired of being sick and tired. Hideous is the word for this abuse. But I am here to tell you that not a single minority group student here has received an MD degree without completing the requirements of the Harvard curriculum as designed by the Harvard faculty.

If these students are substandard, then the white students are also substandard, and we'd better close Harvard Medical School down. . . .

From the statement of the Third World Medical Students Caucus:

Racism in the medical profession is not new. Racism at Harvard is as old as the University itself. Since the time of Dr. Martin Delaney in 1851, who was forced to leave Harvard following a riot by white students against the presence of blacks, minority students have had to overcome unnecessary obstacles to the acquisition of an M.D. degree.

The present attack comes at a time well-chosen for the malignant purposes of those people who would deny equitable representation of Third World students in medical school. It has diverted, to defense, the time and energy of industrious students who otherwise would be deeply engaged in clinical clerkships and in study for final exams. This attack follows closely on the heels of Harvard Medical School's reaffirmation of its commitment to the admission of highly qualified minority students.

The Third World Medical students have asked the faculty of Medicine and the President of the University to reprimand Professor Bernard Davis by entirely relieving him of the responsibility of student evaluation, thus censuring him for remarks that malign the clinical and academic competence of minority students and future doctors.

His statements, initially contained in a *New England Journal of Medicine* article, have been disseminated by the *New York Times* and the national wire services.

His invectives have called into question the judgment of the Medical School Faculty in granting degrees to students whom he characterizes as incompetent.

Statements by the Faculty of Medicine and by Dr. Robert H. Ebert, Dean of the Medical Faculty, have taken the position that Dr. Davis's accusations are not a reflection of the view of the administration or of the faculty as a whole. However, we feel that given the grievous damage done nationally to Third World students by those remarks, nothing short of reprimand and censure would be just recompense.

Excerpts from "A Reply to Dr. Bernard Davis," issued on behalf of the HMS chapter of the Poor White Health Organization:

. . . We come from communities where poverty and lack of adequate health care go hand in hand. . . . People from socio-economically disadvantaged backgrounds, regardless of race, are . . . particularly qualified to deliver quality health care to their communities . . . [E]xpertise in all the sciences including the understanding of the values and needs of working people of all backgrounds . . . is essential for the safe and effective practice of medicine, which anyone who has practiced medicine — which Dr. Davis has not — would verify.

From our personal experiences, we can attest to the fact that on countless occasions poor people have been the victims of ineffectual, bordering on incompetent, health care delivered by physicians who do not understand their particular needs and values. We have seen patients being mismanaged in terms of accurate diagnosis by physicians who by reason of their background have been shielded from working people and thus are prone to misinterpret working people's symptoms. We have seen patients being mismanaged in terms of therapy by physicians who do not understand that working people cannot afford to fit into a physician's 9 to 5 appointment schedule nor bear the cost of therapy. Is it any wonder that working people are demanding access for their children to medical education. . . .

May 19

Statement released by the heads of the preclinical departments of HMS:

As chairmen of the departments responsible for the teaching of preclinical sciences at the Harvard Medical School, we wish to

dissociate ourselves and our departments from the statements in the recent letter by Dr. Bernard Davis in the *New England Journal of Medicine*. These statements, as well as those appearing in the lay press, are unsubstantiated and are damaging to minority medical students and physicians, and to their patients. All students who graduate from the Harvard Medical School have received intensive training in the biological basis of medicine and all have been evaluated by the same academic standard. We feel that the minority recruitment program has made an important contribution to medical education at the Harvard Medical School and in the nation and we will continue to support this program with enthusiasm. We take satisfaction in the high quality of our graduates.

Harold Amos, Ph.D., Neurobiology and
Molecular Genetics
Baruj Benacerraf, M.D., Pathology
Elizabeth D. Hay, M.D., Anatomy
Manfred L. Kamovsky, Dr. Phil.,
Biological Chemistry
Irving Goldberg, M.D., Ph.D.,
Pharmacology
Torsten N. Wiesel, M.D., Neurobiology
Thomas H. Wilson, M.D., Dr. Phil.,
Physiology

Letter to the editors of the *Crimson* from
the co-signers of Dr. Davis's original
document:

The undersigned, all of whom have worked over the years to assist in the development of the minority student program of the Harvard Medical School, take this opportunity to express our satisfaction with, and commendation of the program. We shall continue to give our enthusiastic support to the program, and we encourage the Faculty to take steps to maintain its excellence.

In his comments to the *Harvard Crimson* of Friday, May 14, Dr. Davis did not draw a clear distinction between his personal views and the substance of the statement submitted to the Faculty Council of the Medical School, of which we were co-signers. We are particularly concerned that the report published in the *Crimson* last Friday must have caused undue anguish for many of our students who are members of minority groups.

Furthermore, we strongly deplore the *Crimson's* intemperate account of the matter, and particularly the failure of its editorial staff to check the accuracy of the report published, especially with reference to the document submitted to the Faculty Council over our signatures. The January 13 statement to the Faculty Council, which the *Crimson* apparently did not see, is not an attack on the minority program. It does imply that the program and its graduates would be ill-served if there were any indication that degrees were not awarded on the basis of a single standard.

Harold Amos
Porter Anderson
David Hubel
Manfred L. Kamovsky
Fred S. Rosen

Excerpts from Dr. Davis's letter to the
Crimson:

I must protest the slanted nature of the article by Judith Kogan (May 14) on my recent piece in the *New England Journal of Medicine*. The issue is a complex and delicate one. . . . the *Crimson* started with an outrageously inflammatory headline (Professor Assails Blacks' Performance) and then quoted exclusively the critical aspects of the article. It ignored the parts that made clear my support for minority programs and my desire to see them strengthened by resisting pressures to stretch standards excessively. . . .

The *Crimson* has thus created the false impression that I am criticizing the performance of black students as a whole, instead of emphasizing the need to distinguish a satisfactory from an unsatisfactory student, regardless of ethnic origin. By so distorting the picture the *Crimson* has injured the black community, and also those (including me) who are sympathetic with their needs and aspirations. Indeed, I do not blame anyone for getting angry at my views as portrayed by the *Crimson*.

It is important to correct not only that picture but also any possible connection between the content of the *Crimson* article and the views of Professors Amos, Anderson, Hubel, Kamovsky, and Rosen. They cosigned the original document, prepared for the Faculty Council, that was the basis for my published article, and no statement by me outside that document should be ascribed to them. . . .

The original document was accepted without criticism by the Faculty Council, which unanimously passed two resolutions addressed to the problems. It is thus clear that these problems are widely perceived, by educators close to them, as real and significant. Because this formulation had proved so useful I submitted to the *New England Journal* a condensed and updated version, intended as a reflective comment for consideration by medical educators at other schools. In this article I did not criticize my school — indeed, I am very pleased by the progress we are making. In particular, I did not identify Harvard as the school that had finally awarded a diploma to a student who had failed Part I of the National Boards five times. (I would now like to add that the recommendation for a late award of the degree was based on evidence of subsequent satisfactory clinical performance.) I specifically asked the reporters from the *Crimson* not to identify Harvard Medical School in this connection. . . . the *Times* honored my request; the *Crimson* did not. I apologize to the administration of Harvard Medical School for the result of my indiscretion.

I am very sorry that statements quoted in the press may have led minority students to believe that I have been criticizing their performance as a group. I trust the original document will make clear my recognition of the fundamental success of minority programs in medical schools, and my concern for ensuring good medical care for all segments of society.

Now to the most serious matter of all. The comments by Beckwith and by Fursh-

pan in the *Crimson* represent legitimate disagreements, though it is not clear whether these comments are based on my article or on secondary sources. Lewontin's comments, however, are another matter. He is quoted as saying "[Davis] thinks blacks are mentally inferior and incompetent. . . . [He] argues that these minority students don't have the intrinsic ability to become doctors." Nothing in my article justifies this grave charge. Neither does anything else that I have said or published. I have written to Professor Lewontin demanding an immediate and full retraction.

May 21

Statement issued by Dr. Davis:

I deeply regret my failure to anticipate that my article in the *New England Journal of Medicine*, intended for professionals, would reach the public press. Its misinterpretation by some of those who have commented on it publicly, together with ill-considered subsequent responses of mine to queries from certain newspapers, have caused much harm. For my share of these errors I apologize. My article did not raise any doubts about the quality of minority students or physicians as a group. I do not have such doubts, and it would be utterly contrary to my convictions, both personal and scientific, to make any such generalization about any racial or ethnic group. My only concern is with a very small fraction of the students, both non-minority and minority.

May 24

Letter sent by Dean Ebert to the deans
of 118 of the nation's medical schools:

To the Deans of American Medical Schools:

Such wide publicity has been given to the article written by Dr. Bernard Davis and appearing in the *New England Journal of Medicine* (Vol. 294, No. 20, May 13, 1976, p. 1118), that I feel compelled to write to you in the hope that you and your admissions committee will not be misled by what I can only term irresponsible statements made by Dr. Davis. The article, entitled "Academic Standards in Medical Schools," purports to be a general commentary on the subject, but in fact is a thinly veiled criticism of the Harvard Medical School. He implies that academic standards at Harvard have fallen (unproven) and that some degrees have been granted on a charitable basis. He uses as a single example for the latter charge, the case of a student who had failed Part I of the National Boards five times but was ultimately granted the M.D. by vote of the Faculty. What he neglected to state, because he had not bothered to inform himself of the facts, was that the student in question was granted a degree only after a year of highly satisfactory clinical performance on the wards of a distinguished hospital, documented by letters from all the chiefs of service under whom he served. Nor did Dr. Davis mention that the student had passed Part II of the National Boards. There is nothing to suggest

that this man will be anything but a fine physician. To consider that he might be a danger to patients is ludicrous.

The facts are these: All Harvard medical students are judged by precisely the same academic standards in both the preclinical and clinical years. Some minority students have had academic difficulties along the way, and so have some white students. The faculty has never granted a degree to anyone on a "charitable basis." Dr. Ewalt, Senior Associate Dean for Clinical Affairs, and internship advisor, reviewed in its entirety every record of every medical student graduating in the Class of 1976, and he interviewed all fourth-year students. Not only did he judge that all were well qualified, but he was unable to distinguish between minority and majority students on the basis on their records.

The views expressed by Dr. Davis are his own and do not reflect those of the Faculty or the administration. Enclosed are copies of statements by the Faculty Council and the chairmen of all of the preclinical science departments. Both take issue with the conclusions implied in Dr. Davis's article. The effort of the Harvard Medical School to recruit minority students has been a success and the Faculty vouches for the competence of all its graduates. It is my profound hope that Dr. Davis's statements are not misconstrued by members of your faculty or by your admissions committee and are not interpreted to mean that Harvard is drawing back from its commitment to minorities or that our minority graduates are any less competent than any others. Such is not the case. I also hope that you will continue your own efforts on behalf of minority students and will not permit the pronouncements of Dr. Davis to alter your present admission policies.

I would consider it a favor if you would share this letter with members of your admissions committee.

May 28; June 17

In Dean Ebert's letter to the *Crimson* and in his guest editorial in the *New England Journal of Medicine*, he essentially repeated the content of the letter to medical school deans, and added the following statements (the passages below are taken from the *NEJM*; the *Crimson* letter is worded somewhat differently):

The Harvard Medical School uses a pass-fail system of grading in the preclinical portion of the curriculum and does not calculate class standings. Grades are given, however, in the clinical years, and the grades A and B are considered honor grades. Since students do not take all of the same clinical courses, it is difficult to compare overall performance. However, all students are required to take "core" clerkships in medicine and surgery. The registrar has reviewed the records of all students graduating in 1974 and 1975 and has calculated the percentage receiving honor grades in both medicine and surgery. For the Class of 1974, 66 per cent of the total class received honor grades in both clerkships, and 50 per

cent of minority students received honor grades in both. For the Class of 1975, 79 per cent of the total class and 74 per cent of the minority students received honor grades in both clerkships.

One measure of quality of medical students is internship selection. I have personally reviewed the results of the internship matching plan for Harvard medical students in the Class of 1976, and I am unable to distinguish any differences in the quality of internship appointments for minority and non-minority students. Minority students have been appointed to a variety of high-quality internships, including the Massachusetts General Hospital (medicine), Los Angeles County Harbor General Hospital (medicine and surgery), University of California Hospital, San Francisco (medicine), Presbyterian Hospital, New York City (medicine), University of Texas Southwestern Affiliated Hospitals, Dallas (medicine), Yale-New Haven Medical Center, New Haven, Connecticut (surgery), Children's Center University Hospital, Seattle, Washington (pediatrics), Stanford University Hospital, California (medicine), Bronx Municipal Hospital Center, New York City (pediatrics), and Peter Bent Brigham Hospital, Boston (medicine). . . .

As Dean, I can reaffirm that Harvard Medical School takes pride in the quality of all its graduates and that all have completed a rigorous medical education. It rejects the notion that any of its graduates might be a danger to the public because of inadequate preparation. And finally, the Medical School reaffirms its commitment to the education of able minority students.

Alumni officers, councillors voted in

Even though alumni balloting was off slightly more than in previous years, a new slate of officers and councillors has been elected to the Alumni Council for 1976-77: president-elect: Thomas B. Quigley '33, treasurer: Fiorindo A. Simeone '34, Fifth pentad (1951-1955): Karl F. Austen '54, Second pentad (1966-1970): Nina Tolkoff-Rubin '68, At Large: Grant V. Rodkey '43A. All councillors serve for three years. The alumni association is grateful to the other nominees for these positions who were not elected: Howard Ulfelder '36, Rustin McIntosh '18, Granville C. Coggs '53, Winthrop A. Burr '69 and Wesley L. Furste, II '41.

MAINE COAST



11 acres of high land with 250' on bold open ocean. Spectacular views and crashing surf. Abuts Reid State Park in Georgetown. Protected area. Near Bowdoin College in Brunswick. Only 2½ hours to Boston. \$50,000

This is but one of the many outstanding properties we have available in the choice regions of Maine, New Hampshire and Vermont. We specialize in locating, evaluating and marketing high quality land in Northern New England. We would be delighted to review your investment objectives with you.

For more information on the above property, or to receive our selected list of multi-acre parcels, return the coupon to Mr. Peter Barber, Dept. HM, 743 Washington St., Newtonville, MA. 02160, or call anytime (617) 965-3100.

Name _____
Address _____
City _____
State _____ Zip _____
Tel. _____

Northland investment corporation

CORRECTION! Henry P. Godfrey '65, who was listed among past recipients of the Moseley Travelling Fellowship in the March-April HMAB, p. 3, informs us that his work under the fellowship was with Professor P.G.H. Gell, in the department of experimental pathology, University of Birmingham Medical School, Birmingham, England – not with Dr. J. H. Humphrey of the department of immunology at London's National Institute for Medical Research, as we mistakenly reported.

CLASSIFIEDS

Cataumet, Cape Cod: 2¼ acres directly on Windsor Cove overlooking western approach to Cape Cod Canal. Magnificent location. Large, comfortable house, separate garage, boathouse. Own dock and mooring. Complete privacy yet easily accessible. Family oriented community. 1¼ hours from Boston. Ideal for children and pets. Contact: Dorothy Rackemann, days (617) 734-3300, Extension 438; evenings (617) 354-7469.

markable fund raising activities. Maxwell Finland has raised upwards of five million dollars endowment for the Medical School, which included his donating many of the monetary prizes he has received for medical excellence throughout his professional life.

Northern California alumni enact constitution

The Harvard Medical Club of Northern California has finally enacted a constitution and bylaws after three years of effort. Approximately thirty-five alumni attended the first meeting of the year, held on May 11, at which time officers were elected for 1976-77: president: Thomas Moore, Jr. '56, vice-president: Rodman Starke '58, and secretary-treasurer: Paul Altrocchi '56.

Executive committee members were elected for posts of from one to three years' duration. Those elected for a one year term, 1976-77: J. Engelbert Dunphy '33, Benson Roe '43A, Malcolm Watts '41; for a two year term, 1976-78: Charles Barnett '27, Thomas Hunt '56 and John Mills '66; for a three year term, 1976-79: Charles Noble, Jr. '29, Bruce Sams, Jr. '55 and James Thompson '40. All alumni in the Northern California area are invited to become active members of the Harvard Medical Club, which is located in San Francisco; meetings are semi-annual, with the next one planned for this fall.

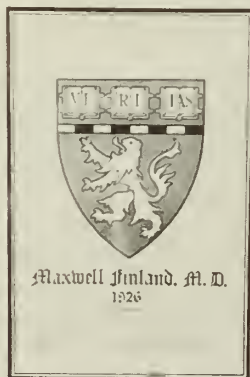
Dr. Finland, who is the George Richards Minot Professor of Medicine Emeritus, has been a "distinguished physician" of the Veterans Administration for the past two years, visiting numerous hospitals and medical centers in the nation.



The singular achievements of Dr. Finland were also heralded by his classmates at their fiftieth reunion dinner. On their behalf, Theodore Badger presented Dr. Finland with a specially designed, gold-framed certificate, symbolizing his most special place in the Class of 1926.

Alumni salute Maxwell Finland '26

During the Alumni Day proceedings on May 27th, Maxwell Finland '26, a preeminent member of the fiftieth reunion class, was honored by Chase Peterson '56, vice president for alumni affairs and development at Harvard. Dr. Peterson named the three areas in which Dr. Finland has made exceptional achievements: medical research in pneumococci and later work in the mechanism of antibiotics and infectious diseases; administration of the Thomdike Laboratory and of the Second and Fourth (Harvard) Medical Services at Boston City Hospital; and re-



presented to him by his classmates at the fiftieth reunion of the Harvard Medical School. The certificate is a symbol of the appreciation for his exceptional achievements and his singular place in the Class of 1926. It is a tribute to his many accomplishments in the field of medicine and his service to the Harvard Medical School and the Harvard Medical Services at Boston City Hospital.

Class of 1980 arriving shortly

Out of an applicant pool of 3,670 — fourteen per cent larger than last year's — the admissions office staff and the admissions committee and subcommittees have labored to bring forth the HMS Class of 1980. The following figures show the composition of the applicant pool, and of the group of candidates offered and holding places in the incoming class as of July 6, 1976. According to director of admissions F. Sargent Cheever '36, some small shifts may still occur before registration, as some offers of admission may be declined and extended to other candidates.

Of the 2,632 men who submitted applications, 112 have been offered places in a first year class of 165. The remaining 53 places are held by women, chosen from a female applicant group of 1,038. Applications from members of minority groups (including Native Americans, Blacks, Orientals, Chicanos, Puerto Ricans and other Spanish Americans) declined to 499 from last year's 590; however, the number of minority students accepted is 37, as it was last year.

Graduates of Harvard and Radcliffe colleges will again account for almost a quarter of the incoming class, with 31 Harvard men and 11 Radcliffe women offered places out of applicant groups of 216 and 66, respectively. Thirty-five alumni offspring applied for admission and 6 have been offered places; 9 faculty offspring (2 of them also counted as alumni offspring) applied and 2 are now holding places in the prospective class (one of whom is the child of an alumnus). More than a quarter of all the applicants, 815, were the progeny of physicians (including alumni and faculty), and fully one third of the places in the class have been offered to the sons and daughters of physicians.

The Harvard-MIT Program in Health Sciences and Technology, which ac-

counts for 25 of the places in the incoming class, will be made up of 19 men and 6 women; 3 of the total are members of minority groups. A complete list of the members of the HMS Class of 1980 will be published in the fall.

Where have all the funds for research gone?

A parting of the ways between federal funding agencies and biomedical research conducted in universities and medical centers, has come about through what Dean Robert H. Ebert has termed misunderstandings. Congress has expected monies invested in medical research to "pay off," while various funding agencies believe that funds expended for research are solely payments for service. Such attitudes — and lack of support — have proven detrimental to medicine since it "has significantly reduced the numbers of promising young scholars entering into academic medicine," according to Dr. Ebert, who spoke on the deteriorating partnership between government and medical research at a recent meeting of the Association of University Radiologists in Boston.

Dr. Ebert was critical of the methods Congress is contemplating to change the distribution of specialties and physicians, which would thwart medical schools' attempts to plan more effectively to alleviate the burgeoning costs of a medical education. "Primary care has suddenly become fashionable and is perceived as a kind of panacea for all our medical care problems . . . No developing nation, including Russia, has solved the problem of geographic distribution of physicians. It is unlikely to be solved by emphasizing primary care training alone." There has been a dramatic increase in the number of US medical school graduates who are choosing to pursue careers in primary care (general practice, family practice, internal medicine, pediatrics, and to a certain extent, obstetrics and gynecology), from fifty-six per cent in 1974 to sixty-six per cent this past year. Yet the problem of geographic distribution will

not be remedied by a different ratio of specialists, asserted Dr. Ebert, "but in a variety of different ways through organization."

Prout '41 now in charge of internship advising

Curtis Prout '41 has been named chairman of the Internship and Residency Advisory Committee. Dr. Prout, assistant clinical professor of medicine, Harvard University Health Service, assumes this function, which formerly was encompassed in the duties of Jack R. Ewalt, M.D., senior associate dean for clinical affairs, who recently retired as an emeritus, and has been appointed director of the Veterans Administration's mental health and behavioral sciences service in Washington, D.C.

In his new position, Dr. Prout will be concerned with advising and counseling fourth year medical students as they seek hospital internships, and he will author the famous internship letter that accompanies each student's application file to the various hospitals that are in the internship matching program.

Dr. Prout is a private practitioner in internal medicine and senior associate at the Peter Bent Brigham Hospital. He was previously director of the Massachusetts Prison Health Project, and during the preceding eleven years, chief of medicine and associate director of the Harvard University Health Services. He is a former president of the Norfolk District Medical Society, 1971.

Goodenough wins 1976 Boylston award

With more than three hundred votes cast by all four classes, Daniel A. Goodenough, Ph.D., assistant professor of anatomy at Harvard Medical School, received the 1976 Boylston Society Award for teaching excellence.

The award is given on alternate years to a member of the clinical or basic science faculty. Dr. Goodenough, who has been teaching histology since 1971 and has been assistant professor since 1972, is involved in teaching the histology course for first year students. The winner with a wide margin over the other eleven nominees, Dr. Goodenough was particularly liked by the students for his informal review sessions.

Dr. Goodenough received his Ph.D. degree from the Harvard Medical School department of anatomy in 1970 while working for Dr. J. P. Revel.

Biophysical Lab 30 years later

The Biophysical Laboratory celebrated the close of its third decade of service and research in a two-day symposium on June 14 and 15. Over the course of thirty years, the laboratory has grown from a staff of one graduate student working with director Arthur K. Solomon, Ph.D., D.Sc., (now also professor of biophysics), to a group of twenty — including an assistant professor, an instructor, a lecturer, two research fellows, two research associates, and three graduate students in biophysics.

Entitled "Molecular Specialization and Symmetry in Membrane Function," and made possible by a grant from The Commonwealth Fund, the symposium brought together leading national and international figures in cell membrane function for discussions under three major headings: specialization at the molecular level, asymmetry in transport, and polar faces in epithelia.

At its inception, the mission of the Biophysical Laboratory was to provide assistance in work with radioactive isotopes and establish initial regulations for the use of radioisotopes throughout the University. Over the years the scope of the laboratory has broadened considerably, and it is now considered one of the world's leading centers in studies of cell membrane

permeability. Observes Dr. Solomon, "Our research concern then, as it is now, was the mechanism of the transport of substances such as sodium and potassium across cell membranes, a field that has grown dramatically and excitingly over the three decades. Our interests then were exclusively nuclear as applied to the use of radioactive isotopes in biology and medicine. In the intervening years the laboratory's research involved other biochemical and biophysical approaches, including micropuncture and microanalysis, to the study of cell permeability. The work has provided quantitative foundations for present permeability studies on red blood cells.

"Today, it seems we have come full cycle. Once more our research focuses on the atomic nucleus. Our newest instrument, a nuclear magnetic resonance spectrometer, provides a technique to capitalize on the properties of stable isotopes to obtain new and revealing information about molecules of biological significance."

Understanding of gastrointestinal and renal physiology has also benefited from the work of Dr. Solomon and his colleagues. Particularly important was the 1957 discovery (with Dr. Peter Curran) that absorption of fluids from the intestine is coupled quantitatively to simultaneous active transport of sodium. During the past three decades, 416 communications have been published concerning the research activities of the Biophysical Laboratory.

Moore '39 resigns Moseley Professorship; Mannick '53 named successor

Francis D. Moore '39, Moseley Professor of Surgery at Harvard Medical School and head of the department of surgery at the Peter Bent Brigham Hospital, resigned those positions effective June 30, 1976. "After many years working with the marvelous opportunities that I have had, it is time that I step aside for a younger man with new

ideas and vigor," stated Dr. Moore. "The groundbreaking for the Affiliated Hospitals Center last December marked the beginning of a dream that goes back two decades. I hope to devote my full effort in the next few years to assist in the realization of that hope."

During his nearly thirty years' tenure at the Brigham, the department of surgery has pioneered the application of metabolic and isotope techniques for a better understanding of surgical physiology and convalescence, and new methods for intravenous feeding and the biochemical management of surgical patients. The surgical department has become renowned for undertaking the earliest work in kidney transplantation in this country, assisted by the Brigham's departments of pathology and medicine; the development of mitral valve and later, open heart surgery; and the development of new approaches to the treatment of breast cancer. Other facilities were established and integrated into the department's organization: a gynecologic unit, a cardio-thoracic unit, a division of plastic and reconstructive surgery and a bioengineering department. The range of surgical services, including inpatient, outpatient and emergency ward, has doubled under Dr. Moore's leadership as surgeon-in-chief.

Francis Moore is not leaving the sphere of academic medicine, however. He has been appointed the Elliott Carr Cutler Professor of Surgery and will continue his research and teaching activities at Harvard and the Brigham. The Cutler Chair, which was established by the President and Fellows of Harvard in 1955, has had only one incumbent, J. Hartwell Harrison, M.D., an international leader in urological surgery who retired in 1975 to become the Cutler Professor Emeritus.

Dr. Moore has contributed to the scientific literature on surgery through several articles and five books, including a history of the development of tissue transplantation, *Give and Take*. He has held numerous government positions and currently is a member of the panel on specialty and geographic distribution of physicians of the Institute of Medicine, an outgrowth of his work on the distribution of surgical care in the US during the past five years.

Assuming the Moseley Professorship in Surgery at Harvard Medical School and with it, heading the department of surgery at the Peter Bent Brigham Hospital, is John A. Mannick '53. Dr. Mannick's research interests are in the field of vascular surgery, where he is a recognized leader who, with his associates, has isolated a substance from human plasma which has been shown to play a key role in the suppression of the immune response in patients with cancer.

Carried out in the late 1960s, this research involved isolating an alpha globulin from normal human plasma having the ability to inhibit the transplantation immune response, which Dr. Mannick named immuno-regulatory alpha globulin (IRA). It acts by interfering with antigen recognition by thymic derived lymphocytes T-cells(/) and is effective in inhibiting T-cell dependent immune responses, but ineffective in suppressing B-cell mediated responses. With this knowledge, Dr. Mannick and his colleagues then demonstrated a correlation between a diminished sensitivity to specific antigens in patients with cancer, and the presence of an immuno-suppressive peptide fraction in the serum, which resembles IRA. These observations led to the formulation of the theory that the accumulation of high concentrations of circulating immuno-suppressive peptides contributes to the failure of some cancer patients to muster an effective immune response against their tumors.

Other of Dr. Mannick's achievements in vascular surgery include the development of procedures which improve

Dr. Mannick



blood circulation to the extremities in elderly, high risk patients. Dr. Mannick has also gained the respect of medical students and house officers for his teaching ability, which he has demonstrated since 1964 at the Boston University School of Medicine. His various faculty positions there have been first as associate professor of surgery, as professor of surgery in 1966 and, in 1973, as the Utley Professor of Surgery; he was also chairman of the division of surgery, surgeon-in-chief at University Hospital and director of surgical services, Boston Department of Health and Hospitals. Dr. Mannick also held the position of chief of the sections of vascular surgery and transplantation at the Boston University School of Medicine.

Nelson becomes Joe V. Meigs Professor

James H. Nelson, Jr., M.D. became the Joe Vincent Meigs Professor of Gynecology at HMS, chairman of the division of gynecology at the Massachusetts General Hospital, and chief of staff at the Vincent Memorial Hospital on July 1. Dr. Nelson's leadership is expected to inaugurate "the development of new educational programs necessary to bring gynecology at the Hospital more directly into the mainstream of the specialty and to develop leaders at a national level," according to Charles A. Sanders, M.D., general director of the MGH. More specifically, the gynecology division will be forging new ties with the MGH general surgical services division and with the department of gynecology at the Boston Hospital for Women Division of the new Affiliated Hospitals Center, Inc.

Dr. Nelson's previous post was as professor and chairman of the department of obstetrics and gynecology at the State University of New York, Downstate Medical Center. He had administrative responsibility for obstetrical and gynecological services at State University Hospital and Kings County Hospital Center, and was responsible for thirty residents, a nurse midwife training program, and a large

family planning program. The focus of his research and contributions to the scientific literature is on gynecological malignancy and the thymo-lymphatic system. His 1969 book *Atlas of Pelvic Surgery* is now in its second edition.

Since 1969, Dr. Nelson has been a member of the advisory committee on clinical investigation of the American Cancer Society, and he is also a member of the society's national committee on clinical fellowships. He serves on the state advisory board of the American Association of Physician's Assistants, is chairman of the surgical forum, American College of Surgeons Section of Obstetrics and Gynecology, and is a consultant to the National Naval Medical Center in Bethesda, Maryland. In 1970, he chaired the national program for oncology of the American College of Obstetricians and Gynecologists.



Dr. Nelson

The Meigs Chair, established by the President and Fellows of Harvard University in 1955, honors Dr. Joe Vincent Meigs, a clinical professor of gynecology, who was chief of staff at the Vincent Memorial Hospital — an institution dedicated to the treatment of diseases of women — from 1931 until his retirement in 1955. In 1937 the Vincent Memorial was amalgamated with the Massachusetts General as the MGH gynecological service.

For the present, there will be two Meigs professors: Howard Ulfelder '36, incumbent of the chair since its inception, will continue in that capacity until his retirement in 1978.

Burke first to hold Benedict Chair

John Burke '51, a world leader in the field of surgical infection, inflammation, burn wound metabolism and wound healing, has been named the first Helen Andrus Benedict Professor of Surgery at HMS. Dr. Burke, who has been on the Harvard faculty since 1957, was most recently professor of surgery and is currently a member of the department of surgery and the general surgical services at Massachusetts General Hospital and chief of staff at the Shriners' Burn Institute of Boston, as well as a senior lecturer in mechanical engineering at the Massachusetts Institute of Technology.

Dr. Burke's clinical and research interests over the past fifteen years have been in the area of the prevention of infection, wound healing and burns. His initial work on inflammation and infection established the effective period of preventive antibiotics, which then provided a rational basis for reduction of infection in surgery. Dr. Burke's investigative work on the mechanism of wound healing, the importance of the early excision of burns and immediate primary closure of the burn wound, and his studies on wound metabolism and

Dr. Burke



physiology have directly affected and completely revolutionized the field of burn and wound care. Dr. Burke was instrumental in the development of a frozen skin bank at the MGH, where he is also the principal investigator of the Burn Trauma Center, funded by the National Institute of General Medical Science.

A gift from the Surdna Foundation to the Harvard Medical School in 1975 provided the capital for the Benedict professorship. Mrs. Benedict, for whom the Chair is named, was president of the Surdna Foundation, founded by her father, until her death in 1969 at the age of eighty-one. Harvard was the recipient of other gifts from the Surdna Foundation; the initial one in 1962 established the John E. Andrus Teaching and Research Fund.



Dr. Hedley-Whyte

satisfactory. In 1952 he started experimenting with plastic catheters, which would be of superior quality, and thirteen years later he incorporated the manufacture of plastic catheters as the National Catheter Corporation, which became a wholly owned subsidiary of Mallinckrodt, Inc. of St. Louis in 1974.

Both the International Standards Organization and the American National Standards Institute have welcomed Mr. Sheridan's work. He has been a liaison among various medical organizations such as the American Society of Anesthesiologists, the American Association of Respiratory Therapists and the American Thoracic Society in helping draft standards that have gained worldwide acceptance.

Hedley-Whyte named new Sheridan Professor

John Hedley-Whyte, M.D., professor of anesthesia at the Harvard Medical School and since 1969, anesthesiologist-in-chief at the Beth Israel Hospital, has been named to the newly created David S. Sheridan Professorship of Anesthesia and Respiratory Disease. Dr. Hedley-Whyte's research is in the area of blood-gas measurements, in which he has made valuable contributions to temperature correction.

The Chair, established by the President and Fellows of Harvard, has been endowed by a gift from David S. Sheridan of Argyle, New York, a pioneer in the design and construction of medical catheters, especially those used for tracheal intubation during long-term controlled ventilation of patients in respiratory failure. Catheters designed by Mr. Sheridan are also widely used in anesthesia.

When he entered this field in 1939 as co-founder of the United States Catheter and Instrument Corporation, all catheters were made of rubber or gum Arabic, both of which were not entirely

The most costly mistake in Retirement Planning. Procrastination!

At some point in your career as a self-employed professional — whether your a physician, lawyer, consultant, or what have you — you realize that you have to plan for your retirement income. It usually happens in December — when the tax man says, "You could use another deduction!", and you pop \$1500 into a retirement program.

You get the tax deduction of course. But, you also get two distinct and expensive disadvantages: (1) writing a single check for a whopping \$1500 dollars (2) losing the potential earnings you might have accrued if you had paid in throughout the year.

So wouldn't it be better to invest monthly in an IRA plan?

With an IRA, you don't have to write one big check. And your plan has growth potential from the start.

Remember, you pay no tax on your IRA contributions — or on the earnings of your mutual fund shares — until you retire and begin withdrawing from your account.

And it's likely that by then you'll be in a lower bracket with double personal deductions.

Thus a smaller tax bite.

IRA plans are available to wage earners or self-employed persons who do not belong to a qualified profit sharing, pension, or other retirement plan. And members may set aside up to 15%, but no more than \$1500 dollars of yearly gross income, tax deductible.

Let Fund Research and Management, Inc. send you all the details about the tax deductible Individual Retirement Account, using Pioneer and Pioneer II mutual funds. Just fill out and mail the coupon below

Pioneer Fund and Pioneer II, Inc.



For more complete information about Pioneer Fund and Pioneer II, Inc., including charges and expenses, send for prospectuses from:

Fund Research and Management, Inc.
28 State Street, Suite 3190
Boston, Mass. 02109

Read it carefully before you invest.
Send No Money.

Name _____

Address _____

City _____

State _____

Zip _____

HMA

Internship List

Acheson, Louise S.
University of Washington Affiliated Hospitals,
Seattle, *Family Practice*

Alger, Lindsay S.
Mount Auburn Hospital,
Medicine

Aller, Raymond D.
University of California Hospitals,
San Francisco, *Pathology*

Amaro, Rafael A.
Los Angeles County Harbor General Hospital,
Medicine

Appelbaum, Paul S.
Soroka Hospital, Beersheva, Israel,
Medicine

Auchincloss, Hugh
Massachusetts General Hospital,
Surgery

Bakal, Curtis W.
Presbyterian Hospital, New York,
Pediatrics

Baranano, Eduardo C.
Baltimore City Hospitals,
Medicine

Bassett, Robert L.
Beth Israel Hospital,
Surgery

Batchelder, Timothy J.
University of California Hospitals,
Los Angeles, *Pediatrics*

Bazylewicz, Gregory A.
North Carolina Memorial Hospital,
Chapel Hill, *Family Practice*

Benacerraf, Beryl R.
Peter Bent Brigham Hospital,
Surgery

Beoris, Peter A.
San Francisco General Hospital,
Flexible

Bittner, Marvin J.
University of Michigan Affiliated Hospitals, Ann Arbor, *Medicine*

Blackstock, Dale G.
Harlem Hospital,
Medicine

Bollin, Kenneth W.
University of Iowa Hospitals,
Iowa City, *Family Practice*

Bonventre, Joseph V.
Massachusetts General Hospital,
Medicine

Bowen, Adoniram V.
Glencove Community Hospital, Glencove,
New York, *Family Practice*

Bridges, Kenneth R.
Massachusetts General Hospital,
Medicine

Brooks, Barry H.
Cleveland Clinic Hospital,
Medicine

Brooks, Stephen M.
Los Angeles County Harbor General Hospital, *Medicine*

Brushart, Thomas M.
Beth Israel Hospital,
Surgery

Bump, Thomas E.
Presbyterian Hospital, New York,
Medicine

Carney, Stephen
Los Angeles County Harbor General Hospital, *Surgery*

Carrillo, Juan E.
Cambridge Hospital,
Medicine

Clattenburg, Richard N.
Children's Center, University Hospital,
Seattle, *Pediatrics*

Cohen, Richard J.
Peter Bent Brigham Hospital,
Medicine

Croteau, Louis J.
First Colonial Family Practice Center, Virginia Beach, *Family Practice*

Curry, Wesley A.
University of California Hospitals,
San Francisco, *Medicine*

Daulaire, Nils M.
University of Colorado Affiliated Hospitals, Denver, *Family Practice*

Davila, Fidel
Baylor College AFL-Houston,
Medicine

Davis, Aloysius L.
West Virginia University Hospital,
Morgantown, *Psychiatry*

Diesk, Andrea
University Hospitals,
Madison, Wisconsin, *Medicine*

Druckman, Hope L.
Children's Hospital Medical Center,
Pediatrics

Eaton, Dagna Z.
Eastern Maine Medical Center, Bangor,
Family Practice

Federico, Francesco
Sepulveda VA Hospital, Sepulveda,
California, *Medicine*

Fenichel, Robert R.
University of California Hospitals,
Los Angeles, *Medicine*

Fenton, Bradley W.
Hospital of the University of Pennsylvania, *Medicine*

Ferraro, Nalton
Massachusetts General Hospital,
Oral General Surgery

Fishman, Mark C.
Massachusetts General Hospital,
Medicine

Fleischman, Roger A.
Peter Bent Brigham Hospital,
Medicine

Flyer, Richard H.
Bronx Municipal Hospital Center,
Pediatrics

Fram, Robert J.
Presbyterian Hospital, New York,
Medicine

Frank, Deborah A.
Children's Center University Hospital,
Seattle, *Pediatrics*

Fuchs, Richard M.
The New York Hospital,
Medicine

Ganz, Peter
Massachusetts General Hospital,
Medicine

Garber, Seth L.
San Diego County University Hospital,
Medicine

Gardner, Phyllis I.
Massachusetts General Hospital,
Medicine

Garza, Homero R.
University of Texas SW Affiliated Hospitals, Dallas, *Medicine*

Gatter, Mary A. Boston Hospital for Women, <i>Ob/Gyn</i>	Heath, Paul M. Mayo Graduate School of Medicine, <i>Surgery</i>	Lange, Louis G. Peter Bent Brigham Hospital <i>Medicine</i>
Germain, Ronald N. Peter Bent Brigham Hospital, <i>Pathology</i>	Herzog, Eugene L. North Carolina Memorial Hospital, Chapel Hill, <i>Family Practice</i>	Lazarus, Nancy B. Roosevelt Hospital, New York, <i>Medicine</i>
German, Deborah C. Strong Memorial Hospital, <i>Medicine</i>	Ho, Mary T. University of California Hospitals, San Francisco, <i>Medicine</i>	Lee, Daniel C. University of Washington Affiliated Hospitals, Seattle, <i>Medicine</i>
Gibbons, Raymond J. Massachusetts General Hospital, <i>Medicine</i>	Horowitz, Gary L. Strong Memorial Hospital, <i>Medicine</i>	Lenoir, Zemmar Martin Luther King Jr. General Hospital, Los Angeles, <i>Medicine</i>
Glickel, Steve Z. Presbyterian Hospital, New York, <i>Surgery</i>	Hrdy, Daniel B. University of Michigan Affiliated Hospital, Ann Arbor, <i>Medicine</i>	Levada, Andrew J. Boston City Hospital, <i>Medicine</i>
Glimcher, Laurie H. Massachusetts General Hospital, <i>Medicine</i>	Jacobs, Marshall L. . Massachusetts General Hospital, <i>Surgery</i>	Levenson, David J. Peter Bent Brigham Hospital, <i>Medicine</i>
Godine, John E. Massachusetts General Hospital, <i>Medicine</i>	Johnson, Carolyn E. Children's Hospital of Michigan, Detroit, <i>Pediatrics</i>	Lightfoote, Johnson B. Stanford University, <i>Medicine</i>
Goldenheim, Paul D. Beth Israel Hospital, <i>Medicine</i>	Johnson, Douglas C. St. Louis University Group Hospitals, <i>Medicine</i>	Lillehei, Craig W. Massachusetts General Hospital, <i>Surgery</i>
Goldhaber, Samuel Z. Peter Bent Brigham Hospital, <i>Medicine</i>	Johnson, Randall D. Beth Israel Hospital, <i>Medicine</i>	Livelli, Frank D. Presbyterian Hospital, New York, <i>Medicine</i>
Gomori, John Newton-Wellesley Hospital, Newton Lower Falls, <i>Medicine</i>	Joseph, Michael P. New England Deaconess Hospital, <i>Surgery</i>	Lofgren, John P. The Medical Center, Columbus, Georgia, <i>Family Practice</i>
Graff, Louis G., 4th St. Vincent's Hospital, Worcester, <i>Medicine</i>	Judelson, Debra R. Kaiser Foundation, San Francisco, <i>Medicine</i>	Lyons, James A., 3d Massachusetts Mental Health Center, <i>Psychiatry</i>
Green, Laurie R. Stanford University Hospital, <i>Medicine</i>	Kent, Dolores R. Los Angeles County Harbor General, <i>Flexible</i>	Magarian, Howard S. Massachusetts General Hospital, <i>Pediatrics</i>
Greenwald, Mark J. Michael Reese Hospital, Chicago, <i>Medicine</i>	Kircher, Lorence T. University of Colorado Affiliated Hospitals, Denver, <i>Family Practice</i>	Maizels, Evelyn T. Z. Northwestern University Medical Center, Chicago, <i>Medicine</i>
Guyton, Sigrid E.P. Peter Bent Brigham Hospital, <i>Surgery</i>	Knighton, Daniel J. Stanford University, <i>Medicine</i>	Mansfield, Frederick L. Peter Bent Brigham Hospital, <i>Surgery</i>
Haith, Linwood, R. Jr. Yale-New Haven Medical Center, <i>Surgery</i>	Kohler, Ted R. Peter Bent Brigham Hospital, <i>Surgery</i>	Matheson, Jean K. Beth Israel Hospital, <i>Medicine</i>
Hannas, Andrew R. University of Miami Affiliated Hospitals, <i>Family Practice</i>	Kramer, Peter D. University Hospitals, Madison, Wisconsin <i>Medicine</i>	Matthews, Sheldon H. Cook County Hospital, Chicago, <i>Family Practice</i>
Hanson, Eric C. T. Massachusetts General Hospital, <i>Surgery</i>	Kulik, Janice E. Rhode Island Hospital, Providence, <i>Medicine</i>	McCabe, Robert E. Harvard School of Public Health,
Harden, Harold W. St. Paul's Hospital, Dallas, <i>Medicine</i>	Lake, Roger F. Montefiore Hospital Center, <i>Family Practice</i>	Merriam, George R. Presbyterian Hospital, New York, <i>Medicine</i>
		Montes, Juan L. Z. Los Angeles County Harbor General Hospital, <i>Medicine</i>

Moore, Francis D., Jr. Peter Bent Brigham Hospital, <i>Surgery</i>	Ruttum, Mark S. Children's Hospital Medical Center, <i>Pediatrics</i>	Tam, Yong-Yong San Francisco General Hospital, <i>Flexible</i>
Moore, John W. M. Army Medical Department <i>Family Practice</i>	Saletan, Stephen L. The New York Hospital, <i>Medicine</i>	Taylor, Simeon I. Massachusetts General Hospital, <i>Medicine</i>
Navarro, Daniel A. Kaiser Foundation, San Francisco, <i>Medicine</i>	Samarel, Allen M. Mount Sinai Hospital, New York, <i>Medicine</i>	Tillman, Ulder J. ('75) University of Texas SW Affiliated Hospitals, Dallas, <i>Medicine</i>
Nelson, Leonard B. New England Deaconess Hospital, <i>Surgery</i>	Savoia, Maria C. San Diego County University Hospital, <i>Medicine</i>	Tucker, Margaret A. Stanford University, <i>Medicine</i>
Newfield, Stanley, A. Brookdale Hospital Center, Brooklyn, <i>Medicine</i>	Scheidlinger, David J. General Hospital Ventura County, Ventura, California, <i>Family Practice</i>	Van Hoosear, Lewis L. Public Health Service Hospital, Brighton, Massachusetts, <i>Flexible</i>
Nierenberg, David W. Beth Israel Hospital, <i>Medicine</i>	Schiff, Jack A. Mount Sinai Hospital, New York, <i>Medicine</i>	Watson, Rita M. Hospital of the University of Pennsylvania, <i>Medicine</i>
Nierman, Eliot H. Hospital of the University of Pennsylvania, <i>Medicine</i>	Sellergren, Kim R. University of Iowa Hospitals, Iowa City, <i>Orthopedic Surgery</i>	Weinberg, Joel M. Peter Bent Brigham Hospital, <i>Medicine</i>
Nordin, Charles W. NYU-Bellevue Hospital, <i>Medicine</i>	Shiang, Elaine L. Peter Bent Brigham Hospital, <i>Medicine</i>	Weiner, Ira R. San Diego County University Hospital, <i>Medicine</i>
Oldham, Brent A. Children's Center, University Hospital, Seattle, <i>Pediatrics</i>	Shilling, David D. Doctors Hospital, Seattle, <i>Family Practice</i>	Weinrich, Michael University of Chicago Affiliated Hospitals, <i>Medicine</i>
Parnes, Jane R. Massachusetts General Hospital, <i>Medicine</i>	Sinak, Lawrence J. Mayo Graduate School of Medicine, <i>Medicine</i>	White, Perrin C. Johns Hopkins Hospital, <i>Pediatrics</i>
Pfister, Stephen J. University of Colorado Affiliated Hospitals, Denver, <i>Surgery</i>	Skee, James R. NYU-Bellevue Hospital, <i>Medicine</i>	Williams, Richard F. University of California at Davis Affiliated Hospitals, <i>Medicine</i>
Poliner, Jay R. North Carolina Memorial Hospital, Chapel Hill, <i>Family Practice</i>	Slutsky, Gerald M. Peter Bent Brigham Hospital, <i>Surgery</i>	Wilson, Richard D. North Carolina Memorial Hospital, Chapel Hill, <i>Family Practice</i>
Ramenofsky, James A. San Diego County University Hospital, <i>Medicine</i>	Smith, Brian R. Peter Bent Brigham Hospital, <i>Medicine</i>	Wolfe, Gail R. Z. Beth Israel Hospital, <i>Pathology</i>
Ramsey, Bonnie W. Children's Hospital Medical Center, <i>Pediatrics</i>	Steinberg, Susan F. Presbyterian Hospital, New York, <i>Medicine</i>	Wolfe, Lawrence C. Children's Hospital Medical Center, <i>Pediatrics</i>
Rivera, Jaime H. Bronx Municipal Hospital Center, <i>Pediatrics</i>	Stern, Eric H. Presbyterian Hospital, New York, <i>Medicine</i>	Wolfson, David M. Mount Sinai Hospital, New York, <i>Medicine</i>
Roberts, Riggs B. San Diego County University Hospital, <i>Family Practice</i>	Stock, John L. Beth Israel Hospital, <i>Medicine</i>	Wong, Edward S. Montefiore Hospital Center, <i>Medicine</i>
Rossing, Thomas H. Peter Bent Brigham Hospital, <i>Medicine</i>	Styrt, Barbara Roosevelt Hospital, New York, <i>Medicine</i>	Wu, Earnest Boston City Hospital, <i>Pediatrics</i>
Russell, William E. Massachusetts General Hospital, <i>Pediatrics</i>	Swerdlow, Charles D. Los Angeles County Harbor General Hospital, <i>Medicine</i>	Zufall, Kathryn A. Virginia Mason Hospital, Seattle, <i>Flexible</i>

Alumni Day 1976



*“Our understanding of the traumatic
of the playing field . . .
has long since spilled over
to all of medicine.”*

Schuss-boom, tra-la!

by Arthur E. Ellison

You might wonder how one is chosen to speak for the twenty-fifth reunion class. My career not only has evolved over the twenty-five years of our postdoctoral life, but contains within it the essence of a basic conflict confronting the health care delivery system in America today. I refer to specialization in a time of crisis in the demand for primary care.

Arthur E. Ellison '51 has academic appointments at Harvard, the University of Pittsburgh and the University of Massachusetts, where he is head of the department of sports medicine. A former national medical advisor to the national ski patrol system, he is now special consultant, national ski safety research; orthopedist and team physician at Williams College; and a team physician for the US National Ski Team.

First, permit me to refresh your memory of the evolution of my own medical career. At the fifth reunion of our class I was completing an orthopedic residency here in the then untorn and quite wonderful city of Boston. By 1961 — our tenth — I was engaged in orthopedic group practice in Williamstown, Massachusetts, but had developed a deep interest in an emerging field, nameless at the time, but now known as sports medicine. When we gathered together for our fifteenth some of you may recall that as a result of a great boom in the growth of the sport of skiing, fortuitous local geography and a successful appeal for HEW funds (the specialist must have grant money!) I was deeply immersed in the investigation of the pathomechanics and therapeutics of skiing injuries. By 1971, however, it was obvious that my scope was far too broad and if I was to wash out a nugget of truth, all interest in

cross-country skiing and ski jumping had to go. In a word, by 1971, you might say I was full time in downhill skiing.

Nor have the centrifugal forces of specialization ceased spinning. I appear before you today, at our silver convocation, having abandoned the totality of downhill ski trauma and now do little other than rebuild wounded knees for alpine skiers. Nor did such single-minded dedication go without just reward. Throughout the world — but particularly behind ski school desks — one encounters what, for want of modesty, is known as Ellison's Law. “The incidence of injury in skiing tends to be lower in those skiers who do not fall down.”

There is a delightful symmetry in all of this. Some of you, of course, are deeply and seriously involved in the delivery system for health care and will see such

specialization as part of the problem. Others have expressed a distinct interest in getting a piece of this action. In truth, there is plenty of action to get. We have come a long way since Galen was team physician for the gladiators. Some seventeen million Americans, approximately the population of all of Canada, sustain injury in the pursuit of recreation and sport each year. With the ever shorter work week and gradual awareness of the rewards of physical fitness, we had best not overlook the medical aspects of sports and recreation. Fortunately F still equals MA, and while it is true that neither the mass nor the acceleration on the playing field approaches the severity of that on the highway, when Dick Butkus was on a blitz or Dave Schultz puts his heart into a forecheck the forces can, as they say, exceed physiologic limits. Then, too, don't forget turf toes, swimmer's shoulders, baseball fingers and tennis elbows. That's not only sports medicine, but primary care and the kind I suspect that many of you personally know the best.

The history of sports medicine is provocative. Talk sports medicine with the aging stars of yesterday and you receive a broad smile — injury was part of their game. They were cared for on the field by teammates. Still later, the coach was on the sideline to bind up the wounds so the athlete could return to play. The serious injury went home to the concern and care of parents — with good fortune, to return to play again.

The doctor entered this relationship precariously. The vicious cycle of inadequate knowledge of athletic injuries and especially of athletes and their motivation, led to the standard admonition to give up the game. The athlete, fearful of being denied his expression, avoided the doctor until the severity of his problem guaranteed such a recommendation.

Then came the pioneers: Gus Thorndike of this university — perhaps the father of sports medicine in this country — and still later his active successor and a personal mentor of mine, Bart Quigley. The physician studied and became a member of the team; physical examinations were done; believe it or not, rules were changed; the humanity of coaches was elevated; athletic trainers began to train and some-

one else was hired to wash the socks; equipment improved; exercise modalities reflected the American genius and became enormously efficient and incredibly expensive. In truth all these improved the quality of care — and dramatically increased the cost! Some of you may see the parallels here between sports medicine and other areas of health care. You may wish to reflect on them when told that the costs of health care are to be controlled or reduced.

The last time we piled empty beer cans on the Circle of Tugo outside Vanderbilt Hall and left this wonderful place to pursue more enlightened things, no one had invented the phrase sports medicine. Now, every respectable medical school and many major hospitals, including those on this campus, have full departments and generous research budgets. Hospitals may receive PR dividends such as headlines that happen to mention that "Bobby Orr Reenters Mass. General." Every screw and wire in Jim Plunkett's acromioclavicular joint had its whereabouts reported on a daily basis here in Boston last fall. The local media watcher could have become a do-it-yourself separated shoulder man. The only thing he might not have understood is why Plunkett chose to go to Palo Alto for his surgery.

You might assume from this that the athletic star is a key. There is some truth to this. If no self-respecting basketball player would consider less than a million dollar contract these days, one would assume that his physician might be a bit of a star himself. ("Himself" may be sexist, but it is also accurate thus far.) Good physicians did *not* always treat good athletes, however. One could reasonably date the modern era of sports medicine from the arrival of that \$400,000 pair of weak knees from Beaver Falls High School by way of Alabama, gentleman Joe Namath.

If those of you who are vitally concerned with primary care, especially for the disadvantaged, grow restless from such stories of people as valuable properties, let me reassure you. Our understanding of the traumatics of the playing field and the resultant improved quality of care has long since spilled over to all of medicine. Even more important has been the rapid

translation of the epidemiologic sports injury studies into workable modes of prevention. Nowhere has this been more dynamic than in the care of the student athlete, and I am pleased to tell you that Massachusetts is second to none in these efforts. We are now in our third year of developing and refining programs to safeguard the health of the student athlete in the Commonwealth. These programs, conducted in conjunction with the University of Massachusetts Medical School and generously supported by the Department of Public Health, have had the flattery of emulation in several states across the country. They are one of the most enjoyable facets of our work.

Perhaps that is the only real message here — the skiing, the pathomechanics of ski trauma, the magnificent mystery of the human knee, the care and friendship of athletes from little league to big league, the search for the prosthetic replacement of the anterior cruciate ligament — all of it has been great fun. Not that there haven't been moments. I was at the basketball Hall of Fame dinner recently and Edward "Moose" Krause, the famed athletic director at Notre Dame and three time All-American, was being inducted. It was a joyous moment and "Moose" was thanking one and all for making it possible. His wife was seated below the head table with the wives of two or three other inductees all radiating the love that such moments bring. After mentioning several important figures in his life, he turned to his wife and began, "Through many difficult times I have had the support of a wonderful wife. I have had twenty-six years of happy marriage —" At which point she interrupted with the exclamation, "Thirty-six!" "Twenty-six out of thirty-six is not too bad," said the "Moose."

You all recall Oliver Wendell Holmes's formula for longevity: "Develop a chronic disease and take care of it." As with so much that Holmes wrote I suspect that there is a broader application than the obvious. Based on careful personal observation, I do not believe that a marriage is *exactly* a "chronic disease," but I rather suspect that Moose Krause "takes care of" his. Then too, the joy of our medical practice is not precisely equivalent to longevity, but it sure is nice to develop a chronic interest and take care of it.



*"... a hospital based military doctor
can gain refreshment and
even inspiration from working
directly with the operational forces.
He really sees what the Navy does."*

Reflections in the wake -- two decades of Navy medicine

by Tor Richter

*The Service, the Service,
you ought to join the Service.
The Army, the Navy,
at very generous pay. (sings)*

That stirring recruiting song was a show-stopper at the 1951 Aesculapian Club extravaganza. Its lyrics, and especially its percussive climax: *Da Dum Di Dum Di Dum* gave lighthearted if heavyhanded expression to a truth as enduring as most anything else we were taught during those four years: military medicine is not every Harvard graduate's cup of tea. Well, first-nighters, here it is twenty-five years later, and a few of us marched off to a different drummer. Surely you will not ex-

Tor Richter '51 entered Navy service in 1960. His assignments have taken him aboard Polaris submarines, to Japan and to exotic Washington, D.C. Most recently he has served as commanding officer for the Naval Research Institute at Bethesda, Maryland. Since 1974 he has been commanding officer of the Naval Regional Medical Center at Camp Lejeune, North Carolina.

pect a cautious bureaucrat — "full of high sentence but a bit obtuse" — to attempt anything offhandedly cosmic. A few "sea stories," perhaps, ventured less for their intrinsic interest than for the parallels they may call up in your own experience. No pearls, then, but with luck maybe a few grains of sand.

One generally thinks of the military in terms of uniformity and interchangeability of parts. For the physician, nothing could be farther from the truth. My career as a Navy doctor has been typical only in its variety. I have had a mixture of clinical, administrative and operational assignments. In peacetime, naval hospitals are similar to civilian hospitals. And of my administrative duties the less said the better. I will speak of my experiences in operational medicine.

A medical officer assigned to operational duty quickly acquires an altered perception of the concept of the fitness of the environment. Sailors and Marines experience adverse environments far beyond those encountered by

all but a small number of adventurous civilians. Heat and cold, wind and wave, weight and depth, noxious creatures great and small.

Not only are military environments severe and unforgiving, but they lack the potential for being brought under control that is common in civilian life. Thus the farmer can rid his stable of rats, his fields of venomous snakes. He will heat his house and find safe water. An invading force crossing those fields or occupying that house does not have the luxury, at least for a time, of environmental control. Therefore in the military the emphasis must be on individual protection, rather than on what by contrast might be termed the public health approach to the prevention of disease or injury. What used to seem to me the maniacal interest of the armed forces in immunization is a manifestation of this phenomenon.

Yet these adverse environments, like other adversities, have their sweet uses as well. They represent workings of nature apart from the beaten path no less

than do rare diseases or genes gone astray. Here also we may expect to find clues that clarify normal physiology and biochemistry. A simple example from diving physiology — the diving injury known as “squeeze” — may help illustrate this. Everyone who has dived even in a moderately deep pool knows that you must equalize the pressure in your ears and sinuses in order to avoid pain and injury. Naturally the air to do this comes from that already in the lungs. Unless one has a scuba tank or an air hose, this gas supply is limited to whatever was inhaled prior to the dive. The “obvious” prediction then is that the depth limit of breath-holding diving is determined by the ratio of gas in the lungs to that in the rigid air containing chambers such as the middle ear, trachea and sinuses. This ratio is roughly five to one which translates as a breathhold diving limit of five atmospheres absolute or 165 feet. In actuality, dives to depths greater than 240 feet have been reliably documented. Though the average Navy diver is sometimes credited with wearing a size fifty-two coat and a size six hat, we know that other factors must be at work. There is during breath-hold diving an intrathoracic shift of blood which greatly reduces the residual volume. In short, a human under these conditions behaves rather more like a diving mammal than we would have thought when we heard Don Fawcett describe the dugong and manatee a few years back.

The Navy is currently sending more of its medical officers on brief tours to sea than it formerly did. This practice has met with some resistance, particularly from specialists whose experience has been limited to hospitals, and who regard shipboard assignment both as a waste of their specialty training and as potentially threatening if conditions outside their specialty present. Those who have completed sea tours, though, have usually been glad they went. There are several reasons for this. The fascination of the sea and ships is one.

The old prescription of a sea change is good for the doctor too. On a *Man of War*, there is the fascination which familiarity does not diminish in watching complex and dangerous evolutions such as carrier landings and missile launchings. The physician assigned sea duty learns a lot in a hurry, though

most of his new knowledge is not medical in the narrow sense. Nevertheless, medical training permits a view of the ship and its operations that is unique to the medical officers, and with experience he becomes an active participant rather than a mere passenger. He ranges far from his sickbay to inspect the ship, and to participate in emergency drills and occasionally in real emergencies. He comes to see the ship as the site of a thousand potential accidents. Everywhere there is stored potential energy, pressurized flasks, taut lines, unburned fuel. Accident and even disaster prevention are a matter of constant preparation and training. In shipboard safety there are even quasi-philosophical issues such as the amount of time and equipment allocated to preparing for various contingencies. American submarine commanders, for example, give very little attention to escape from sunken submarines. Instead, they concentrate on keeping the submarine from sinking.

The Navy clinician who spends even a short time at sea will better be able to do his job when he returns ashore, for he gains a far better idea of the work environment from which his active duty patients come and to which they return. More than one sailor has appeared at the quarterdeck of his ship, “Full duty, fit for same” in a long leg cast.

Even the most cerebral specialist can enjoy and profit by this sort of practical sabbatical. One of the Brigham surgeons — I think it may have been Professor Moore himself — had an aphorism that there was no such thing as minor surgery, only minor surgeons. So it is also with shipboard medicine.

And there is another more general sense in which a hospital based military doctor can gain refreshment and even inspiration from working directly with the operating forces. He really sees what the Navy *does*. It is a particularly good antidote to the disillusionment which may come from daily reading about national indecision and lack of direction. Best fun of all is to talk to the young men who speak with shining eyes about their respective crafts. Lives depend on them. They are good and they know it. But for the Navy, they might be parking cars and pumping gas looking for that way back to San José.

Operational medicine then, besides being necessary, is educational and stimulating. Few make an entire career of it, though. For most, an early operational tour is followed by further training, clinical or research duties, and if fate dictates, those administrative posts euphemistically called positions of leadership. A Navy career thus tends to converge with civilian medicine. The senior Navy physician, like many of you, approaches his work wondering if he is twisting the right knobs or indeed if the knobs are hooked up to anything. One becomes reflective, and even reflects on reflections.

One of the first things that happened to me after I came into the Navy was to be interviewed by Admiral Rickover. These interviews were conducted in an atmosphere of seriousness which in retrospect seems comic. Most of the things Admiral Rickover said to the interviewee were not intended to put him at his ease. One of the first remarks he made to me that day was, “Richter, joining the Navy Medical Corps is like joining a last place ball club.” I am sure now that he was putting me on, but I took him literally at the time, and an animated discussion followed. I find that even now I cannot think about that exchange without a certain amount of heat — maybe because he touched on something that could so easily be true. The Navy medical officer, with his variety of assignments, is at risk of becoming a dilettante. Frequent rotations of assignment diffuse responsibility, and where many are responsible, none may be in charge. Finally, the Navy needs identity without parochialism. This chronic problem has become acute with the end of the doctor draft and dependence on volunteers. We miss the leavening young physicians bring from civilian life and the understanding they take back with them on their return. Most of all, we face the difficult task of maintaining quality among our volunteers.

I hope George Murphy and the other Aesculapians have kept their voices in tune. It may soon be time for another chorus.



"There were the . . . personality conflicts and professional rivalries spawned then as now by academic jealousy and monetary motives."

Those were the days

by Claire M. Stiles

Two hundred years ago Harvard Medical School was only a vision in the minds of a few forward-looking men. Those were the days when, at a meeting of Boston physicians held in the Green-Dragon Tavern, Harvard Medical School had its inception. Strangely enough, taverns keep recurring in the history of our alma mater, and as recently as 1910, the Medical School was criticized for being too autonomous and having all its faculty appointments made by an elite group of local physicians meeting at Boston's Tavern Club!

There were tumultuous years until Harvard Medical School was finally established in 1782, and there were many more years before it became a medical school enjoying the status and standards of excellence for which we know it.

Mention of a medical school at Harvard College is found recorded as early as 1647 when Mr. Dunster, the first president, petitioned the New England Confederation for funds to obtain books for the purpose of

advancing knowledge in all professions, including medicine — or phisicke, as it was then called. Interestingly, during that period it was virtually impossible to separate medicine and religion. Nearly all physicians were primarily ministers, severely criticized if their medical practice in any way interfered with their religious duties. Both Oxford and Cambridge, however, included medicine in their theological studies. Harvard's second president, Charles Chauncy, although predominantly a "pastor," was at the same time an instructor in medicine.

Prior to the Revolution, the number of competent medical instructors in America was limited. Students who could afford it journeyed abroad for their medical education; they too were few in number and Harvard was sharply criticized for being so lax in developing professional training. Between 1636 and 1750, only fourteen Harvard College graduates ever received M.D. degrees — nine earned theirs abroad and five were honorary awards bestowed by Harvard Medical School in its early years.

Massachusetts lagged well behind Pennsylvania and New York in establishing formal medical education. The colony slipped into the third generation of medical preceptorship, producing less than mediocre practitioners.

Farther south, however, lecture series by such men as William Hunter and Samuel Clossy began as early as 1732, helping to bridge the gap between apprenticeship and medical school. At Philadelphia, William Shippen began systematic teaching of medical subjects on an academic level in 1765. By contrast, it was not until shortly before the Revolution that Harvard graduate James Jeffries delivered the first public anatomy lecture in Boston. His second lecture was cut short by a mob who, having heard of the human dissection involved, carried off his subject, the body of a convict which, incidentally, had been legally obtained. So much for early anatomy in Boston.

In the quarter century preceding the Revolution, teacher-pupil groups evolved, each made up of a teacher and any number of aspiring student-clinicians. Probably the three most influential of these teachers were Joseph Lloyd, Simon Tufts, and Joseph Warren. Lloyd was most notable for introducing new medical and surgical techniques, and for the training of, among others, Joseph Warren and John Jeffries. Warren, first of Boston's medically prominent family and an ardent patriot, was most colorful and is remembered for starting Paul Revere on his now-famous ride. Because of his deep sense of duty, while president of the Provincial Congress, Warren went

Claire M. Stiles '56 is an assistant professor at the University of Southern California School of Medicine and chief of the department of anesthesia at Rancho Los Amigos Hospital in Downey, California.

daily to the camp, trying to rally the re-treating colonial forces, and fought that fatal day at Bunker Hill. He was found lying face down in the mud with a musket ball lodged in the back of his skull. His legacy in behalf of medicine was the development of a two-year course, with no binding contract, but with the duties of apprenticeship to "spread plasters, be general utility man in the medicine room, and be responsor to night calls." Perhaps interns and residents today wonder if these "duties" are simply to perpetuate Warren's legacy. In any event, by the beginning of the Revolution, the results of this mode of teaching had produced about 400 M.D.s and more than 3,500 practitioners throughout the colonies.

Circumstances of the pre-Revolutionary era combined to stimulate intellectual curiosity and to challenge old, long-held doctrines. Bold and innovative thought patterns pressured the colonies to initiate their own medical programs. As early as 1764 there is evidence that Harvard seriously began thinking about a medical school to be associated with the College. Unfortunately, on January 24th of that year, a fire destroyed the school library with its collection of medical writings, anatomical specimens and two complete skeletons — one of each sex — which were being preserved for an anatomy program when the College could afford it. 1764 was also the year the inoculating hospital was established in Boston, an act which finally split the ministry from medicine and provides us with the first example of specialization — inoculation.

Ezekiel Hersey, a Harvard graduate who practiced in Hingham, Massachusetts, provided the first significant monetary bequest for Harvard Medical School. His will provided that one thousand pounds be applied "for the establishment and maintenance of a chair in Anatomy and Surgery." This money was placed "at interest" and was subsequently increased by five hundred and another one thousand pounds from his brother and his widow, respectively. With permission of the heirs, this sum of 2,500 pounds was split for the founding and maintenance of not only the Hersey Professorship of Anatomy and Surgery, but also for the Hersey Professorship of Theory and Practice of Physic.

John Warren, younger brother of the Revolutionary hero, Joseph, was initially a poor student who did not learn to read until age ten, but he managed to gain entrance to Harvard College by the age of fourteen. While at Harvard, John became an extraordinary student. He studied medicine apprenticed first to his brother Joseph and later to Doctor Holyoke in Salem. Like many of the physicians of his time, John was politically active and reportedly was even present at the Boston Tea Party.

During this unstable period of our history the fluctuating value of Continental money contributed to the lack of financial rewards for the practice of medicine. The aforementioned Green-Dragon Meeting was for the primary purpose of establishing a reasonable and proper fee level. John Warren used this meeting as an opportunity to recommend to the Boston Medical Society that since there were nearly a dozen medical students in town, there properly should be a medical school. Probably because of his series of anatomical lectures delivered in 1780 and repeated the following year, Warren was proposed for Professor of Anatomy and Surgery. His anatomy course, attended by President Willard and members of the Harvard Corporation, was so successful that on May 16, 1782, Willard and Wigglesworth, a Professor of Divinity, were appointed as a committee to consider the development of a medical school. On September 19, 1782, they delivered their report which included provisions for a library, dissection, legal procurement of bodies from the General Commonwealth and the examination of students in physic at least once a year. A comment at the end of the report proposed that since there were insufficient funds to support a medical school, it "would be expedient for the Corporation to elect public spirited men of distinguished ability to its professorships who would be willing to accept only the fees obtained from those attending the lectures." Their proposals were adopted, and Warren was asked to draw up plans for the medical school. Described as probably the most self-taught man to undertake such a task in two centuries, Warren enlisted the assistance of Shippen and Rush of Philadelphia, who had recently established the first medical school in America at the University of Pennsylvania.

On November 22 of the same year, the Harvard Corporation voted to appoint John Warren Professor of Anatomy and Surgery. A month later twenty-nine year old Benjamin Waterhouse was named Professor of Theory and Practice of Physic, and in May of 1783, Aaron Dexter was appointed Professor of Chemistry and Materia Medica. Of this great triumverate, only Benjamin Waterhouse, who had studied both here and abroad, had an M.D. degree, obtained in 1781 from the University of Leyden. Dexter and Warren were both products of the apprentice schools, but subsequently they received honorary medical degrees from Harvard. The bicentennial years certainly have brought a striking contrast in qualifications for Harvard faculty.

Boston's newspaper, the *Continental Journal and Weekly Advertiser*, carried an announcement on September 18, 1783, of the opening of the Medical Institution at the Cambridge site. With a series of lectures attended by twenty students and members of the College senior class who had obtained parental permission, Harvard Medical School was off the ground during the winter of 1783-84. Perhaps "off the ground" is a somewhat misleading phrase, since the first lectures actually were given underground — in the basement of Harvard Hall.

Nor was the sailing to be smooth once the good ship HMS had been launched! Four major storms were to be weathered during that first quarter century. There were the usual, perpetual personality conflicts and professional rivalries — spawned then as now by academic jealousy and monetary motives. Waterhouse and Warren were openly in conflict, periodically accusing each other of such things as "deceit, double-dealing, lying, and slander." A rival is said to have once commented that Warren would have little trouble procuring bodies for dissection — grave robbing would be entirely unnecessary since most of the inmates of the Continental Hospital, where Warren was sole director, were foreigners and no one would miss them after their demise. Over the years, Waterhouse had acquired an extremely overbearing, pedantic manner. Moreover, he neither desired nor built up a practice. Because of his attitude that "patients bored him," he was unpopular not only

with colleagues, but also with students. As a result, Waterhouse experienced early forced retirement. Nonetheless, he is credited with one of the most important medical contributions of the era, the introduction and acceptance on a scientific basis of a vaccination for smallpox.

Another problem then, as now, was the difficulty in procuring funds. This seems to be a constant thread running throughout the history of most universities, Harvard being no exception. An act passed in 1642 established the Overseers of Harvard College and set the school's revenue at 400 pounds from the General Court, plus the income from the ferry between Charlestown and Boston. More than a century later, because of its move to Concord during the Revolutionary War, the lack of recompense for damage to the halls which had housed troops, and the general market depreciation, Harvard lost money. Apparently because of poor management of the funds, College Treasurer John Hancock was removed from office by the Corporation. Later, when he became an important figure in post-war Massachusetts government, it is not surprising that the Legislature suddenly discontinued its annual grant to the College. Finally, in 1779, Harvard broke its tradition of having only clergy as members of the Corporation, after which business methods improved. The school became a University by legislative act, and began to appear financially solid by the turn of the century.

Difficulties obtaining anatomical and clinical materials for teaching purposes, as well as hospital facilities for in-house training was another turbulent issue. Especially in the larger towns, a few students apparently were permitted to examine bodies of persons who had died from "extraordinary diseases," and occasionally limited anatomical study was allowed following accidents or public executions, but for the most part dissections and demonstrations had to be carried out in private societies on skeletons delivered by members — undoubtedly the source of acquisition was never questioned.

As early as 1784 attempts were made to gain permission for Harvard's medical professors to care for the sick in the Alms House in Boston. However, the Boston Medical Society vetoed the

idea, thinking that Warren would turn this opportunity to his own financial advantage. This distrust and jealousy resulted in postponing the use of the Alms House until 1810 — twenty-six years lost for medicine and patients.

As an alternative for in-hospital training, HMS substituted preceptorships with Harvard graduates who set up local centers of medical teaching. Students pursued a required three-year course, two winters attending the basic lectures in Cambridge and the remainder of their time with these clinical preceptors. The bachelor of medicine degree was awarded the student who successfully completed this training; an M.D. degree involved more advanced study, until 1811, when this two-stage process was eliminated.

Simultaneously there was the struggle to establish excellence in medical practice. The aim of the Massachusetts Medical Society, established in 1781, was to develop a reputation equal to that of the Royal College of Physicians in London. Thus the Society set standards so high that only thirty-one candidates qualified, twenty-three being Harvard College graduates. The Society also established strict academic requisites ending with a rigid examination. Members were then permitted to examine candidates and issue certificates of competence. This practice brought them into conflict with the University, which felt it had the sole right to grant such certificates. Eventually, both groups realized they were striving for the same ideals. (In the early 1800s the Massachusetts Medical Society tried unsuccessfully to unite with Harvard and move the medical school to Boston.) Six years after its founding HMS graduated its first class — George Holmes Hall and John Fleet. Fleet was chosen by Warren to help in anatomy and surgery, and thus became the first Assistant appointed in the Medical School.

Growing pains became the fourth major storm for HMS in that initial quarter century. In that era there was no bridge across the Charles River and anyone living in Boston, rather than in more expensive Cambridge, often had to travel eight miles through Roxbury and Brookline to reach his destination — without bus, car, or trolley. In winter, it must have been a long, cold walk.

The medical lectures moved into Holden Chapel in Cambridge by 1801. Four years later John Collins Warren, son of the first surgical professor, began a course of anatomical lectures over White's Apothecary Shop in Boston, located on what is now Washington Street, between School and Summer Streets. When the Medical School finally moved to Boston in 1810, this inauspicious site became its new home for the following six years. With the growth of the faculty to eleven professorships, six of which were in the Medical School, the site again changed in 1816 to Mason Street, where, in recognition of the annual \$10,000 state donation, the name temporarily became the Massachusetts Medical College. Another move in 1847 to the North Grove Street Building, near the Massachusetts General Hospital, and a further move in 1883 to Exeter Street occurred before the final move to these marble halls in 1906. Thank goodness, seventy years later we are still here!

As I researched for this program, I became acutely aware of the value of retrospect. We review the change in methods of teaching from preceptorship to didactic lectures designed to supplement the preceptors. Gradually the academic lectures became all-important, with clinical training following the degree. Now we have a combination of it all, broadened to include laboratories, hospitals and clinics. We recall the original faculty of one physician-professor, expanded to what it is today, continually striving for excellence despite internal rivalry, gypsy-like moving, and at times virtually no salary. Years have been devoted to diverting medical practice from the hands of apprentices, midwives and quacks. Today we are training nurse anesthetists, paramedics, nurse practitioners, technicians and physician assistants to do what for almost two hundred years had been thought as only within the province of the M.D. Are we finally coming full circle — to realize the value of at least part of the medical scene of two hundred years ago?

I cannot help wondering what physicians standing here two hundred years hence will think as they reflect and compare the time from 1976 to 2176. Will we have completed yet another cycle in history or will they, too, look back and say — "those were the days."



*"... acute medicine should be in the hands
of the young
while family practice or continuing care ...
is best put into the hands
of men and women over fifty."*

Margarine and medicine, or butter is bitter

by Howard M. Spiro

When Perry Culver asked me to speak, he needed a title within twenty-four hours and I promised one that would give me some latitude. That night I went to bed a little sad that I was inescapably an old grad and awoke with a start in the middle of the night to see on the ceiling my title, "Margarine and Medicine." Celestial communications have improved from Nebuchadnezzar's day, I realized, for the words were typed and not in Gothic, nor in the fiery penmanship of that old Babylonian's time.

The title was all very well, splendidly alliterative and all that, but I wondered what the message was! The message was supernatural if not celestial, appropriately enough, since medical knowledge during the past quarter century seems to many physicians to have become one grand progress towards a paradise where there shall be no death. Still I did not know. Then at the American College of Physicians meeting I found the answer in the drug exhibits where food and drug manufacturers insist more and more that we should eat ice-cream made of cellulose, sausages turned out of soy beans, and of course

that splendid balm — as good for unruly hair as for health — corn oil margarine. We physicians have always peddled panaceas to ourselves as well as to others, and margarine could stand for the delusions we feed ourselves as well as others, a modern snake oil. The old mountebank had his snake oil and stood on his bench to sell it to those he could persuade. Today, we use television cameras, electronic platforms and other audiovisual aids to sell the current hardware or snake oil, or even corn oil margarine. Butter tastes good, but it is bitter indeed. We are not hypocrites, for we have already sold ourselves a belief in whatever is fashionable.

One big bottle of snake oil today is labeled family practice for the young physician. Family practice may make sense, but the way that physicians go about preparing for it does not, and who should do it is uncertain. Let us consider these matters briefly as we look at the differences between the young and the old physician. At Yale, my younger colleagues are called to plumb the various body orifices with their new endoscopes (and there are more each year — endoscopes, that is, not orifices). Actually, X-rated movie makers discover more orifices each year too, or at least new combinations of old ones, and since endoscopists now make movies, and good ones, I await the inevitable endoscopic orgy of

writhing satyrs, maids, fiberscopes everywhere, and overall the great God Pan, nowadays short for panendoscope. Yet, to return to my theme, the young do procedures while the older physician is asked to evaluate what they have done, and largely to console and to try to help those with pain which cannot be held up to the light.

Who are the young and who are the old? I hold forty young (a few of you may wonder at my pO_2), and I remember my own view of forty at twenty-five. But the ripple of youth grows ever wider. Not too long ago I had lunch with a young woman physician, face out of Holbein, what I used to call a senior assistant resident or, as we now must put it, a third year post-graduate trainee. Good public relations depends upon changing terms: my neurocirculatory asthenia is now your floppy mitral valve, Yale-New Haven Hospital is now Yale-New Haven Medical Center and its director is now called president, but while the room rates have gone up, nothing else has! The term *intern* and *resident* have been banished as too hierarchically revealing to the patient, or possibly to the third party payees; the graceful term "house officer" is apparently too archaic for those whose lives are largely spent so far from the hospital. As this young woman and I talked, our conversation

Howard M. Spiro '47 is professor of medicine at Yale University School of Medicine. Dr. Spiro recently completed the second edition of his textbook, *Clinical Gastroenterology*.

turned lightly to modern technology, IPPB, nitroprusside, and to Swan-Ganz catheters. Yet our badinage uncovered in this twenty-eight year old woman a fear that she might already have become as technologically useless as I. She had not been on the coronary care unit for a year or so, and worried that when she returned a few weeks hence the new drugs and procedures would have passed her by, and she would have to learn all over again. "We did not unload the left ventricle with nitroprusside back then," she said, "and I have to know how to do it!"

One can be more philosophical in the coronary care unit standing up than from a bed, and so as one looks about there, one sees that the doctors and the nurses are all so young. The nurses wear miniskirts, or did a little while ago, and it surely is not sexist to watch a young girl so clad lean gracefully over an old and purpling man, to dream for a moment; but it is jarring to have such a reverie interrupted by hearing her turn to the resident and ask, "Shall we use the lidocaine drip or just zap him?" There are so few old doctors around these units except in the beds, and there are certainly no grey-haired nurses, although this latter phenomenon may owe a debt more to chemistry than to the times. Indeed the nurses in such units tell me that when they need advice, they turn first to the resident, then to the chief resident, and when he or she cannot give them the answers, they expect no further help from the director of the unit. Now, thirty years from medical school, I had reason for concern about techniques and technology; but this young woman three years graduated was already worried about nitroprusside! We may not be too far from the time when men and women will become archaic between the first year of medical school and the fourth, and if the trend continues we shall surely have to shorten the time of training.

One question you may have is whether this rapid change in technology brings as many benefits as we currently advertise or whether the anodyne of change hides the pain of inability. I am expert in stellate ganglion block and this astounds my younger colleagues; some of you will remember that in the late 1940s and early 1950s this was the panacea for stroke. Ascertain the side

of the stroke, block the stellate ganglion on the other side quickly with a needle of novocain thrust to the cervical vertebra, and watch the Horner syndrome. Many were the dilated pupils, but of course the therapy did not work. The IPPB machines still have their place I hear, but much less so than a few years ago. Still, in the 1960s who would have dared to question them? The Myrmidons descended upon us to set up and control the many valves and levers, while newly appointed directors of units called us all to marvel at the mysteries. No one wished to be old beyond his or her time, an expert in literature of the 1950s, and so we said that butter was bitter, and the cost of IPPB in the United States rose, I understand, to two billion dollars not so long ago. Today, there is less IPPB, and some patients blow balloons prettier than the blow bottles of my youth, but the Myrmidons of respiratory therapy have new ways of doing things which even our house officers do not understand. Was all this corn oil? Snake oil? Margarine? It is hard for me to tell.

Currently, family medicine is the passion to correct matters and especially what seems to be an uneven spread of physicians, from city to country, from subspecialty to general medicine. One proposed solution has been to require some kind of government service for young physicians, with money going to their medical schools in large enough quantities to make sure that they goad a number of their graduates into becoming family physicians or serving in under-doctored areas. The idea of requiring community service from physicians as well as from others seems a good idea to me in this 200th year of the Republic; but the notion that it is the young physician who should go out to battle the disorders of spiritual, economic and social despair makes as little sense as sending Patroclus out to fight Paris! The old doctors are better suited to the task. A seventy-five year old physician, recovered from pulmonary edema with a hematocrit of twenty the day before making rounds in a convalescent home, remarked that after four blood transfusions to a hematocrit of forty, he could make his rounds without a great deal of harm to himself or to his patients and that there might be yet some benefits for both. He might be telling us what we do not wish to hear, that it is

the old who should be doing "family practice."

I have been disappointed that there has been little recent enthusiasm for the physician-extender as a family practitioner. This sensible approach to the problems of medical care is not very popular with the chairmen of departments of medicine looking for money to keep their services going. It is increasingly taken for granted that young physicians must do "family practice" and some of this is based on the idea of the doctor draft. We physicians ought to consider further who should be sent out to the field and whether current plans would make just the wrong age physicians the family practitioners. Fresh from training and technology, the young physicians should be in active hospital practice, handling the acutely ill.

In any case, if there must be some direction of how and where physicians practice, acute medicine should be in the hands of the young, while family practice or continuing care or whatever brand name it takes is best put into the hands of men and women over fifty, father and mother figures and physicians competent enough for the degree of need, who have lived long enough to know that most complaints get better by themselves, who have faith that mind and body are one. In this way the talents of many older physicians might be turned to the lost art of triage, to emotional care and to the kinds of activities which currently are deemed most appropriate for doctors right after four years of medical school and four years of postgraduate training.

No doubt most here will disagree with me, but at an alumni meeting it is appropriate at least to ask who are the young and who are the old and to question the fads of the past twenty-five years for which margarine stands simply as a long lasting symbol. Faith in high technology may be the corn oil of our times, but I believe that technology does save lives and that science is gradually bringing order into medical practice. For that reason, I would organize clinical practice in such a way that the older graduates do the family practice, which is what many of them do anyway, and I would keep the young around the hospital until time and the arteriosclerosis they hope to avoid by eating margarine catches up with them!



“... those most responsible for the various core clerkships had never met together ... to make any effort to standardize their courses”

Alumni Survey Committee: Ombudsman of HMS

by William D. Cochran

First, let me briefly outline the inception of the Alumni Survey Committee. As I am sure you are aware, in the late '50s and early '60s there began a socialization process that came into full flower by the late '60s and might best be encompassed by the double heading of affirmative action and participatory democracy. More faculty-administration committees and student-faculty committees were formed at HMS. The alumni, especially through the Alumni Council, also expressed an increasing desire for more participation. In the hopes of having more influence at the Medical School not only did the council develop its present “pentad system,” electing representatives from each five year group of graduates, but it also felt

the need for a vehicle by which it could look with some depth into topics of concern, hence the formation of the Alumni Survey Committee. We are a group of nine alumni (one of us an alumna), all appointed. We were selected to represent various pentads and geographic areas. All but two of us are presidents of our respective classes. I was asked to be secretary-chairman because I am the only one based in the Longwood Avenue area.

Problems at the Medical School that have come to the attention of our Alumni Council are sifted over by them and those they feel are of most importance and potentially correctable are brought to us for investigation — one by one. We meet for two days twice a year, attending clinical rounds if pertinent or interviewing faculty, administration and students. Sometimes we can wrap up a problem in one such two day session, often we need two or more sessions. (The one person who has done yeoman groundwork for us is Perry Culver. He has lined up representative students and faculty members, arranged meals, housing and meeting rooms for us in his usual friendly and efficient way.)

At the request of the council we have studied and reported three problems to date: the admissions process, student

attitudes and dissatisfactions, and the teaching of the clinical core curriculum. Our most recent task has been studying the problems associated with the introduction to clinical medicine course. Our first study on the Admissions Committee was reported in full in the *Alumni Bulletin* and our third study was reported in the *Newsletter/Focus*. The student attitudes report has yet to see the light of day although we feel that to date, it is our magnum opus.

I will excerpt first from the report of the clinical core curriculum and then from the one on student attitudes. If I sound occasionally negative remember that we were asked to look into problems that seemed controversial as well as current.

We, and the Alumni Council, became particularly interested in the core curriculum when we saw certain answers on the questionnaire sent to students, and also as a result of two lengthy meetings we had had with various groups of students as part of our previous study and report on student attitudes.

What did we learn? Some of the core clerkships were run in a manner that made one proud of HMS. Most teachers were dedicated and worked long

William D. Cochran '52 is chairman of the Alumni Survey Committee. Dr. Cochran is the associate director of the Joint Program in Neonatology at the Lying-in Division of the Boston Hospital for Women, the Children's Hospital Medical Center and the Beth Israel Hospital. The other members of the Alumni Survey Committee are: Joseph W. Burnett '58, Granville C. Coggs '53, Ruth C. Haynes '52, James R. McArthur '56, Donald McLean '43A, Scott Nelson '66, Philip F. Partington '35 and Marshall deG. Ruffin '36.

and hard. Many courses were well-organized, covered appropriate physical diagnosis, core diseases, performance feedback and final student evaluation. Certain teachers were sent letters of commendation by their department chairman. First and most important to us, it became apparent that many of those doing the teaching were rarely, if ever, rewarded or even praised for this task and occasionally were given the impression that they should be devoting more time to research and less to teaching. One of the questions we asked was, "How well do you think good teaching is rewarded at Harvard Medical School?" We asked students to rate the teaching on a scale of 1 to 5 — 1 being beautiful and 5 being not so good at all. The first year class gave a rating of 2-5; the second year a rating of 3-5; the third year also a rating of 3-5, with a number of them down in the bottom; and the fourth year class a rating of 4-5. The fourth year class is always supposed to be the least enchanted, and their ratings certainly reflected it. One of the other comments, from a second year student, was, "only by the applause at the end of the lecture."

Even core teaching therefore is not uniformly a high priority item. We also learned that those most responsible for the various core clerkships had *never* met together to discuss course content, to trade ideas or to make any effort to standardize their courses in any way. Their first meeting together was at a working dinner and discussion with the Survey Committee members. It is obvious that our recommendation here was that formal rewards and/or recognition of outstanding teachers be instituted and at least some academic protection be provided as well. Students reported that occasionally they were demeaned or considered a nuisance in their efforts to learn from the house staff and visits. Besides the obvious recommendations to be made for these latter two weaknesses another major recommendation included a two-way performance feedback so that students could evaluate a course and a teacher as well as the universal opposite. Student evaluations were not uniformly and therefore not fairly carried out, and we suggested remedies for this situation.

The contents and recommendations in our report on student attitudes and dissatisfactions can

be criticised as being not only superficial but also unfairly biased as we could not speak with all faculty, administration, students and even interested alumni. I can only say we tried!

For this report we met for two different two and a half day sessions and also designed a questionnaire to survey all HMS students. Although we got back only a third of these questionnaires, they were a healthy sampling that agreed with the feedback we received from our various talks with students.

Indeed, we recognized that Harvard Medical School with its traditions of excellence and scholarship was certainly continuing to set the pace as far as basic science research was concerned. None of us had any quarrel with this aspect of the HMS educational experience. With the Medical School's ongoing affirmative action program, however, there have been definite and substantial increases in the percentages of women and minority students. For instance next fall's incoming class will have some thirty percent women and eighteen per cent minority students. These percentages have been fairly stable in recent years. Although by no means unique to Harvard, this has led to such problems as the inability of some of the faculty members to identify easily with many of the students. Similarly, it is much less easy for the students to find faculty role models with whom to identify. Many students now feel that no one individual in their respective class can be representative of their particular interests and therefore they refuse to elect class officers. A former dean of students spoke of the honeycombing effect of this new diversity. With the concomitant spread in the academic background of the incoming students, some now having master degrees or more, there has been increasing divergence in the abilities of the students to handle certain course work. Add to this the continued almost logarithmic growth of scientific knowledge and emphasis on research, which has forced the faculty, especially in the preclinical years, to be further and further removed from the primary care interest of a continued substantial percentage of students. Obviously mechanisms must be developed to relieve these problems; one of the most obvious is the need for more communication.

Because of the increasing desire of students for participatory democracy coupled with the added pressures of the diversity among them, they perceived that there often was no structured pathway for decision making if they had a particular gripe about the faculty or administration. Seemingly decisions were often made by one faculty group or person only to be countermanded later by some higher authority. The faculty in turn was discouraged about reaching the students because the latter refused to elect class representatives, claiming that such activity was "sophomoric and Byzantine". Only on a very ad hoc basis would they elect a representative.

Finally, it appeared to the students and to us that those same traditions of excellence and scholarship applied to basic science were not so generally being applied toward setting the pace with innovative programs in medical education, in primary care training and delivery in its many aspects and, lastly, in a biosocial curriculum. Indeed, in some instances HMS did not even seem to be keeping up. There seemed to have been a significant deterioration in the humane interpersonal relationships with the faculty and administration of the kind that the members of the Alumni Survey Committee remembered from their student days. It also was our feeling that the students *do* have an accurate perception of the significant problems, and that the School must address itself to at least some of these problems.

Harvard Medical School must decide whether it is to have one main institutional goal of excellence in basic science research or whether it should have several equally important institutional goals besides this — namely, the development, with equal rigor, of scholarly disciplines in the areas of the biosocial curriculum and in education. The lack of these, if one believes the questionnaire and student interviews, affect student morale as does the low profile of family practice and primary care. In this day and age it seems almost unconscionable and certainly unreasonable that if Harvard could develop over the past eight years the present outstanding HST program with MIT, it should not be as able to develop, if it truly wanted to, a similar and just as exciting program for those many

students anxious to go into one of the major primary care disciplines (particularly weak seemed to be family practice or community medicine). It was pointed out to us by Dr. Ebert that because of Harvard's excellence in basic science HMS has attracted allied funding and hence has a high percentage of total faculty working in these fields. He felt it might be more difficult for Harvard to "turn around" and develop expertise in fields pertaining to most major areas of primary patient care. However, with Harvard's tremendous assets we felt this might not necessarily be so, especially since primary care is now a major emphasis of current governmental training policies.

The continually increasing amount of scientific knowledge makes a coordinated education program at HMS a necessity. The School should certainly develop an educational support or learning resource unit that would collaborate with the faculty helping them to at least explore, if not actually design, effective, coordinated courses capitalizing on modern, time-saving, self-learning techniques. It could also help them design for the future and for smooth modification or change of major courses. Rather than the almost cata-

clysmic eruptions that presently seem to occur every three to five years. Perhaps there should be a new and formal commitment to self-learning, because this is one of the most important aspects of scholarship. Space, equipment and time might be dedicated to this — the Countway Library would be an appropriate place for such a self-learning center.

Many other issues flooded in upon us and we felt they must be addressed openly and soon at the Medical School. At the top of these was the need to rethink and restate the institutional goals of HMS. Less far-reaching but more specific items, including some of those mentioned heretofore, were the deficiencies in preclinical courses and clerkships, and the problem of tenure which now is reserved largely for the research-oriented doctor.

There should be specifically scheduled meetings of each class or of all four classes once or twice a year to which the dean and other key administration and faculty personnel attend *without fail* to communicate issues of concern and engage in discussion with students. Since November seems to be one of the low points in student morale one of the meetings might be scheduled then.

Lastly, we feel we must emphasize again and again that continuing efforts should be made to improve interclass, intraclass and faculty/administration/student communications. The Alumni Survey Committee recognizes the growing difficulties due to the increasing size of the student body, the increased diversity of the student body and the increasing size of the Medical School. Therefore, extra communication effort must be made, and probably this should be done through the office of student affairs. Hence the director of student affairs must be a warm, humane, accessible person in good communication with the rest of the faculty and with enough clout to get problems solved promptly, if possible. This person *must* be provided with a clear statement of the responsibilities and relationships of the position and have an appropriate background for dealing with student problems and frustrations.

William Stewart Halsted is alleged to have asked, "How can a medical student possibly know what he should know?" Lest we be accused of being too clairvoyant ourselves, in this generation of rapidly changing concepts perhaps we should rephrase that question, "In this present age, can *anyone* really know what they should know?"

A response

by Dean Robert H. Ebert

The Alumni Association has for many years been a source of great strength to the Harvard Medical School. I like to think that it is unique among all medical school alumni associations in its commitment to the School. I cannot document that assertion but I have listened to the complaints of other deans about the relative lack of involvement of other alumni groups and therefore judge that Harvard is unusually fortunate. Certainly I can vouch for the support it has given me during my tenure as dean and I could remind you that the past eleven years would not be characterized as the "tranquil period" in the history of the Medical School. This is not to say that there has been unanimous agreement

about everything that has happened in the Medical School and I could never expect it to be so. How could it be, given the consistent policy of Harvard to admit the brightest students possessing the strongest characteristics (and therefore the strongest opinions) that the admissions process could identify.

I do not remember whether it was Perry Culver or I who coined the term "alumni power" back in the days when it was popular to talk of student power. Perhaps it would be better to talk of "alumni responsibility" in today's world, for that would be a more precise way of defining the role of the Alumni Survey Committee. Certainly, the committee

has taken its job seriously and has written several voluminous reports.

How successful has the effort been? In all candor I would have to say that the results have been mixed and I believe I know why. The most helpful and in my view the most critical analysis of an issue was the report on the Admissions Committee. The review dealt with the work of a single committee and one of great importance to the Medical School. Members of the Admissions Committee were interviewed, the operation of the committee was analyzed, specific criticisms were made and a series of thoughtful recommendations were written. This report

led to a full scale review of the admissions procedure by a faculty committee with student and alumni represented. The committee, chaired by Dr. Cheever, issued a comprehensive report which was accepted by the faculty, and the changes recommended are now a matter of school policy.

I have taken some pains to outline the process because it appears to me to be a model of alumni-administration-faculty interaction. The Alumni Survey Committee identified a specific problem area, and I emphasize specific; the administration responded by asking a faculty committee to consider the matter in greater depth; and the faculty accepted the recommendations of the committee.

Let me now comment on what I perceive as the wrong model for such interactions — namely the report on student attitudes and dissatisfaction. This report was critical, but it was not a critical analysis and there is a distinction. The effort failed because it violated a basic principle of committee function. It did not focus its efforts, but instead became involved in so many different issues and problems that the results of the survey were superficial and not particularly helpful. The title of the Survey Committee report sounds reasonably well focused, but the report itself recommended among other things — a catalogue describing everything there is to know about HMS and its affiliated institutions, substantial changes in the curriculum, redefinition of qualifications for faculty promotion, a new self-learning center in the Countway, and new ways for the administration and the faculty to communicate with the student body. Do not misunderstand me. I am not suggesting that these are trivial issues, and they deserve attention. But I do say that none of these was considered in sufficient detail to be useful. Let me use the example of primary care. It was suggested in the report and in Will Cochran's remarks that HMS had done almost nothing in creating innovative programs in primary care training and delivery. If that is true, why does HEW use the Harvard Community Health Plan as the model HMO and why does the Beth Israel Ambulatory Center have visitors from medical centers around the country, and why is the Johnson Foundation supporting a primary care training program which involves the

MGH, Beth Israel, Peter Bent Brigham, Cambridge Hospital, Mt. Auburn and the Harvard Community Health Plan? As usual we are better known outside Boston for what we do, than in the family. My point is that the Survey Committee seemed totally unaware that any of these activities was going on.

This omnibus report was a poor model because the committee tried to address too many issues, it reviewed them superficially and therefore it issued a report of little value. The latest report on the core clerkships is much better since

it dealt with a finite issue. There is now an active faculty committee chaired by Walter Abelmann which is charged with developing guidelines for the ongoing evaluation of teaching.

On balance, the Alumni Survey Committee has been useful to the School and should continue to function. I think it is also fair to say that it functions best when it perceives a discrete problem and does not try to cover the waterfront. Any one of the issues raised in the omnibus review is worthy of study, but one at a time please — not all at once.

Scenes from Alumni Day '76 (Cont'd.)



First, speeches were diligently listened to, especially by this row of upstanding alumni. Afterwards, the most persistent symptom of Alumni Day was all those omnipresent smiling faces, of which we display four specimens: Left, Ralph Wheeler '26 and wife Miriam. We missed having the family portrait include son Paul '61, back for his reunion too. Below, Cliff Barger '43A and George Richardson '46 have to be reminiscing!



Reunion Reports



1921

HMS '21 celebrated its fifty-fifth year reunion with a dinner at the Harvard Club on the evening of Thursday, May 27. During the day the presentations of the scientific program and the informative remarks of Class Day speakers — students and faculty — competed for our attention. The dinner was attended by nine classmates — four from a distance — and six wives. Dorothy Murphy was the guest of honor. Mrs. V. H. Kazanjian, the widow of our late distinguished classmate, joined us for cocktails. Her presence warmly recalled the generous hospitality of their home in Belmont which she, her husband and family had provided for us at the five year intervals of many previous reunions. Dr. Kazanjian attended our fiftieth, but is among the fourteen members of the class who have since died. After dinner, the turn to speak briefly of present activities went round the table and we learned of Dorothy's current work on Harvard Medical history. On Friday, the special feature of our reunion being over, the diverse attractions of Boston and its flowering suburbs led many of us to stray from the notable events of Alumni Day in the quadrangle — a choice of electives appropriate to seniority.

William B. Castle



1926

The all-important factor, beautiful weather, was with us from start to finish of the gathering of those loyal souls from far and near for our fiftieth reunion. It was a great time, seemingly enjoyed by all — a trite, but true statement. Of our seventy-four living members, thirty-five came to join in one or all of our activities. We were especially pleased to have with us Dorrice Barr, Peg Balfour, Lura Boeck, Ann Pratt and Betty Sweet.

The Alumni Day Program had especial significance to our class, as during the proceedings, Chase Peterson, vice president for alumni affairs and development, presented a citation to Max Finland for his contributions to the Medical School and for his many personal achievements. This might have been called Finland's Day, for in the evening at the Country Club dinner, Ted Badger, speaking for the class, presented Max with another expression of our appreciation of his friendship and achievements. The class dinner at *The Country Club* (for those living beyond the aura of Boston and environs, this is the Brookline Country Club), was an unqualified social, epicurean and cultural success. Our accolades to our gourmet treasurer John Strieder for his choice of victuals and wines! We were especially honored by having Dean and

Mrs. Ebert and Dorothy Murphy as our guests. Dorothy has indeed been one of us since the days of our matriculation and, in planning and carrying out our reunion functions, has spent many hours — without her help we never could have managed! As a token of our affection for her and of our appreciation for the many things she has done for us over the years, Hank Gallup expressed the feelings of the class in presenting her with a silver bracelet with inlaid "tiger eye" stones.

Saturday we rendez-voused at the home of Walter and Katherine Burrage, "Kettledrum," in Manchester. Their home is lovely, the grounds running to the rocky shore, the water with many sails both nearby and in the distance. The setting, and especially the cordiality of our host and hostess, made the day a delightful and memorable occasion for all of us.

It is traditional that the bus chartered for the trip get lost enroute — and this year provided no break in tradition (established in 1971). However, all arrived safe and harried in time for the delicious clambake prepared in the best coastal New England style. The one oversight found Ernie and Kathleen Boylen stranded on the sidewalk in Boston, the bus having left. However, Larry Ellis to the rescue and disaster was averted.



What makes a reunion worthwhile? It's hard to define, but for all of us it was a wonderfully pleasant all too brief two days of companionship — and I guess that is what it's all about! Those attending were: Farrow and Miriam Allen, Howard Apollonio, Aristocles and Esther Augustine, Ted and Alice Badger, Peg Balfour, Bill Beetham, Lura Boeck, Ernie and Kathleen Boylen, Fred Bruckman, Walter and Katherine Burrage, Allan Butler, Ed and Lillian Cooney, Paul and Erville Doege, Louis and Ella Dunn, Dean and Mrs. Ebert, Larry and Alice Ellis, Gil Engel, Max Finland, Claude and Marion Forkner, Henry and Betty Gallup, Wendell and Frances George, Gerald Gray, Trygve and Harriet Gundersen, Ted Hannon, Clark and Lucy Heath, Everett and Elsie Kiefer, Don and Myna Kingsley, Jeff and Fran Larkey, Leonard and Lorraine Levin, Bill Lewis, Ken and Carol Mallory, John and Pat McKoan, Dorothy Murphy, Bill and Ethelene Potts, Ann Pratt, Ernie and Adelle

Scott, Dick and Dot Stetson, John and Denise Strieder, Betty Sweet, Tom and Betty Army and Ralph and Miriam Wheeler.

Richard P. Stetson

1931

Following the Alumni Day program on Friday, May 28, a cocktail cruise made its way down the Charles River with forty-five members of the Class of 1931 and their wives aboard the good ship "Holiday." Dinner at Holyoke Center penthouse was thoroughly enjoyed by sixty-seven of us. Afterwards, our class president John P. Hubbard asked us to stand for a moment of silence in memory of our forty classmates now deceased. Then our long distance traveler, Samuel B. Kirkwood, who is president of American University in Beirut, gave a very interesting firsthand account of the present situation in war-

torn Lebanon. On Saturday sixty-seven classmates and wives attended an outing and clambake held at the Kennards' in Newton Center, where besides the conventional entertainments of eating and socializing, a croquet set was available in the flower garden for the sports amongst us. A delectable feast of clam chowder, steamed clams, hot lobster and steak was consumed with great enjoyment, topped off with delicious watermelon. Dorothy Murphy shared the afternoon with us as our guest — to everyone's delight.

Harrison E. Kennard

1936

Of the 106 remaining members of the Class of 1936, some forty-three active and hearty classmates gathered together with wives, children and friends for a splendid evening of refreshments, good food and perceptive discourse on the evening of May 27, in the Museum of Fine Arts in Boston. It was a rare and rewarding occasion reuniting and rekindling old friendships that began forty-four years ago when we first entered medical school in September 1932, being inducted into the mysteries of Modern Physics by Dorothy Murphy, who incidentally informed this writer that she could not attend our dinner because "we were too young." We missed her.

However, spirits were high in vivo and vitro. So we proceeded to dine and delight in kindred interests. Our speakers for the occasion were truly exceptional — Franz Josef von Ingelfinger, the esteemed editor of the *New England Journal of Medicine* and a very much beloved class member, who spoke to us on the continuing need for truth, integrity, the search for facts in scientific journals with the exclusion of persiflage and other cover-ups for poorly conceived ideas. Our second speaker was our forever-young teacher, Olive Cope, professor emeritus of surgery, who continues to teach; indeed his love of the art is such that he taught the second year student — Class of 1978 — who introduced him, the Introduction to the Clinic this past March. Oliver's contribution was full of warmth and fresh with ideas about the unity of mind, body and soul (endocrines), and delicately touched with humor. He is timeless.



The next day, Friday, May 28, we listened to various speakers on Alumni Day; heard the dean praise and then castigate the reports of the Alumni Survey Committee. All had luncheon in the quadrangle together.

The rest of our reunion was pure unadulterated fun. We journeyed to the Harborside Inn in Edgartown on Martha's Vineyard where we did as we pleased, and were served two outstanding meals the evenings of Friday and Saturday — on the latter, New England broiled lobster.

After all the festivities we were proud that for forty years we had been graduates of Harvard Medical School as had the Class of 1941 for thirty-five years, who accompanied us to the Vineyard and shared all the goodies with us, and, in turn thanked us in all sincerity for being their "teachers." In the rather fluid atmosphere of the evening, this remark was the only statement that somehow made us feel ever so slightly aged.

Marshall deG. Ruffin

1941

The Class of 1941's thirty-fifth reunion began on Thursday evening with a gracious cocktail party and dinner at the George Clowes' home in Dover. Thirty-seven classmates accompanied by their wives enjoyed a gala evening marred only by news that Harold Barrett, who had been looking forward keenly to the reunion, had become seriously ill almost on his point of departure for it. All of his classmates have been deeply saddened by the news of Harold's death ten days later.

Following the stimulating Alumni Day program and luncheon on Friday, a majority of the returning class members made their way once more to the Harborside Inn in Edgartown which had been such a success five years before. There they joined several other classmates and their wives who came to the Vineyard directly. The weekend weather cooperated handsomely and afforded opportunities to indulge every taste for local exploration and sport or for loafing and reactivation of old friendships and catching up with classmates' lives. Saturday was high-



lighted by a visit to Edgartown harbor by the Clowes' magnificent ocean racing yawl, "Peregrine," and an opportunity for many to sail the beautiful waters of Nantucket Sound. A second highlight was the Harborside's famous shore dinner, which we shared with our colleagues and friends of HMS 1936.

For all concerned it was a memorable weekend with the inevitable "au revoirs" tempered by thoughts of other reunions to come. On behalf of all 1941 members, our thanks and a "well done" to Curt Prout and Joe Rogers for skillful editing of the informative class report and to John Craig for exemplary performance as reunion treasurer. With special appreciation and pride we salute Perry Culver for his tireless efforts on behalf of the Class of 1941 and for his distinguished services to HMS alumni everywhere.

Alfred Pope



1946

The Class of 1946 met about forty strong to honor their thirtieth year from graduation. We saw some classmates whom we had not seen in thirty years and others who attend these festivities with some regularity. Recognizing that everything in life is relative, our friends seem to be withstanding the storms of life without too much visible evidence of scarring. Our members included research types who are now practicing clinical medicine, and clinical medicine types who had changed their spots to those of researchers. Predictions in the yearbook were about as reliable as politicians' promises in this election year. Some members have achieved distinction in the laboratory, in the operating room, in the executive suite, on the medical ward, in the office, in far off lands and close to home. Most all have contributed and are contributing in a positive fashion.

Our formal festivities included a smashing dinner at the State Street Roof followed by dancing to a swing band which played the music of Benny Goodman, Tommy Dorsey and Artie Shaw. As befitting our advanced age, the chariot turned into a pumpkin at about 11:30. Some harder souls continued the festivities back at their hotel rooms.

The next day saw us at a clambake in Nahant at George Richardson's. The salt air, tennis, badminton and socializing were combined with clams and lobsters for a totally satisfying afternoon.

See you all in five years.

John W. Braasch

1951

Encounter 1951 has ended but with it certain impressions touched us all. We wish all classmates had overcome whatever obstacles prevented their presence, and shared in this rare experience. The first major readjustment was to the changed physiognomies, which after two days re-equilibrated. In fact we all marveled at how little we had changed — pure fantasy. As one watched the low flat tennis forehand drive of Lew Krakauer, one was aware that some things had not changed. We, who had endured mutual traumata, had on occasion found ourselves wanting. We were meeting on new terms twenty-five years later. What was this myth called the "Class of 1951?" Missing were Singh, Damon, Gauchat, Tomchik, Stallard, others. Present were new members, hopefully permanent additions: Selma Damon for one.

We ate and drank in weather not too good but not too bad. We made new friends from old acquaintances. Art Cain impressed me with his comment that his perusal of our red book had disclosed a number of us who had returned to find our roots — like our missing classmate who returned to the soil of Wisconsin. Some academicians talked of their renewal in the private practice of medicine. Charley Goodrich spoke eloquently about all of this and symbolized the renewal on a parking lot in Harwichport when he emerged to find



a group of dyspeptic, grumbling, hung-over early morning risers. Grabbing Ned Dreyfus he remarked, "what you all need is a hug" . . . and this was true. That symbol of the reuniting showed us something about ourselves. Earlier in the week at the Harvard Club (where we supped an excellent repast and saw other reuniting groups) our class president Tut had expressed his prayerful gladness that we had been spared to do our work in the last twenty-five years, and we all agreed.

It was a remarkably touching weekend, devoid of what I thought we would find — a cloyingly maudlin nostalgia. Instead I found something which I think will become an enduring impression and last in us as long as we can recall whatever it was that we called Harvard Medical School in those days long gone. It will always be typified by a scene I encountered as we left. A world famous scientist was deep in conversa-

tion with another classmate who was berating himself after these twenty-five years, for he felt that he had been a practitioner without numbers of publications or heady fame. The scientist said, you have achieved something very important, you practice medicine and your patients love and respect you. You are a doctor. This is my paraphrase but it says something which characterizes the real success of those men who made up 1951. Dr. Arbutnot would have been proud of all of you.

Howard S. Yaffee

1956

A score of years represents enough time for many profound changes to occur in the lives and fortunes of a group like ours. I'm sure that I speak for the approximately forty classmates and their families and friends who partici-



pated in various aspects of our twentieth in conveying a sense of enthusiasm and pleasure that came from the rekindling of friendships.

On Thursday a scientific symposium for alumni ran concurrently with Class Day for the Class of 1976, with Franny Moore, retiring Moseley Professor of Surgery, providing a satirical and witty principal address. Many classmates gathered informally on Thursday evening at a hospitality suite at the Copley Plaza, confused by a slight error in planning by the alumni office that put three classes in a three-room suite! Each class refused the bathroom and bed-filled bedroom, so the third room became a bobbing sea of familiar and strange faces cooled by appropriate iced spirits and warmed by renewed friendships.

Superb weather continued for Alumni Day and addresses, which included the contribution of Claire Martin Stiles and a presentation by Chase Peterson. Over buffet lunch and beer, classmates gathered at the Class of '56 umbrella and conversation flowed with ease amongst smiling faces and clicking cameras.

By late Friday most of us were on our way to Chatham Bars Inn on Cape Cod. Away from the distractions of the city and phones, a relaxed gathering of twenty-four classmates and families crowded a lot of living into a splendid weekend. Apart from a sumptuous lobster-clambake, in which everyone participated with gusto, was time for physical activities like beach walking, jogging, swimming, tennis, bird-watching and "card games." The chemistry was right for renewal of friendships, and the physical surroundings included a large private meeting area where we talked and drank. Thanks to the sensitivity of John Grover, we were entertained by movies and slides of Medical School days, Class Day 1956, and pictorial memories of our tenth and fifteenth reunions.

A sense of our togetherness was expressed in a phone call to Harry "The Hat" Zehner in Washington, D.C. and a chance for his gathered classmates to let him know that we wished better health allowed him to be with us and that he was there in our thoughts.



Those that made the journey from *outside* the Boston area included Gene Ciccarelli, the Bob Cotsens, the Hank Edmonds, Bob Goodell, Firmon Hardenbergh, Emma Kroll Harrod, the Ray Hochmans, Herb Kaufman, the Norm Levines, Jim McArthur, the Al Millers, the Joe O'Malleys, Geof Paul (San Francisco), the Al Perlmutter, the Mat Powells (Belvedere, California), the Irwin Roths, Parvin Saidi, the Gardner Smiths, the Bob Stells (San Angelo, Texas), Claire Martin Stiles (Downey, California) and Charlie Young.

Special thanks to Dick O'Hara for arranging the Chatham weekend, Joel Alpert for generously sharing the class treasury and Bob Goldwyn and Roz Steinhardt Frim for their efforts with the reunion booklet. In addition, Larry Baker, Lon Curtis, John Grover and Peter Reich worked and worried over the arrangements.

The test of a successful reunion is the spirit of friendship generated by the event. All of us came away with a sense of renewal and many discussed plans for the twenty-fifth and how we would all work to get an even larger group together to share a meaningful experience.

Arnold N. Weinberg

1961

To all of you on the West Coast for whom the distance was too great; and to all of you in the Great Midwest who like to stay at home:

Your reunion committee sends greetings and sincere regrets that you did not make it back for our fifteenth. We had a good time the whole time, but the high point was during the clambake when the A-M's were defeated in softball by the N-2's — at least that is what we M's claim. Of course with over fifty men, women and children on the playing field any claim is bound to be disputed. It was hard to tell how many were on first, let alone who.

Helen and Peter Randolph's place in Wareham was ideal for bringing together sixty-one adults and fifty-seven kids for a clambake: a beach for swimmers, a wind for kite fliers and plenty of sun for everybody.

Sixty-three attended the dinner and dance on Friday but there was more talking and drinking than dancing. Where are all the serious dancers that we had five years ago?

Out of 145 classmates, forty-four attended all or part of the celebrations. Most were from New England but several came from New York, Pennsylvania, Maryland and Virginia. The real travelers, however, were Bill Yahr from Miami, the Mosers from San Antonio and the Johnstons from Cleveland. We hope to see more of you next time and would welcome your suggestions for activities because we have no idea how to match the Great Clambake of '76 at the Randolphs.

Jim Warram



1966

Ten years later and not a day older, the Class of 1966 returned to Boston from all over the country, literally from Maine to California. On Thursday evening after the scientific program, the first class activity was graciously hosted by Phil and Linda Stubblefield at their home on Pill Hill. Fifty classmates and wives, joined by faculty members Amos, Erickson, Kuffler and Potter, enjoyed the potables and conversation until well into the night. This may explain the light turnout for the early speeches on Friday morning's Alumni Day program. By noon — lunch and picture time — a surprising number had gathered on the quadrangle.

Friday evening the class dinner on board the *Discovery* at the New England Aquarium attracted forty couples and Ned Cassem. The evening was clear and warm, the view of the harbor spectacular and the dolphin show entertaining. The company, food and drink were good, and even the recording of our second year show playing in the background couldn't spoil a fine evening.

The outing on Saturday afternoon was at the Dedham Country and Polo Club. Seventy-five members of our generation and thirty-five of the next praised the sun and wind, and played tennis, frisbee, softball and three-legged races. The California Marmors were a little upset by the speed of the clay courts, but we needed that and old tennis balls to slow them down! The number of good tennis players in the class came as a pleasant surprise to many of us, with several of the distaff having made great progress since the days on the center court at Vanderbilt Hall. The final gustatory event of the reunion was a

repeat of the magnificent New England clam and lobster bake we had enjoyed at our fifth.

Altogether sixty-two classmates made it to one event or another during the weekend. We would liked to have seen the others in the class, and we hope they will join us for the next reunion; we think they missed a good one.

Carlton M. Akins

1971

The Class of '71 had its fifth reunion beginning with a cocktail party at Vanderbilt on Friday evening. The next day was spent at the Donaldson's, Mac-Gruders Farm, in Lincoln, picnicking. What was it really like to come together after just five years?

The cocktail party was little different than so many shared by the class over the years. Twenty-two alumni returned to the starting point (remember that first cocktail party), poured their own drinks and ate cheese and hors d'oeuvre's. Yes, we could still easily recognize each other, although in individual cases the bald spots had extended over the frontotemporal areas. Conversation ranged from the familiar topics (where are you now, training, practice or research plans) to reacquainting ourselves with personal details (starting practice isn't so easy . . . only three kids so far?). The scene was similar (Vanderbilt never changes) and even Tom Wright was able to attend and reminisce about his recent artistic endeavors (rather than directing in the Simmons girls).

But the next day was so much more like those older days. We spent a beautiful



afternoon in Lincoln on the tennis courts, with open spaces and pleasant relaxation. Yet how the class had grown! At least one-quarter of the "class" seemed to be two to four years old. Experiences shared by those present ranged from playing tennis and drinking beer to diaper changing and group toilet training for the kids. The Cleveland contingency (Tom Jones and Jane Fossum, Janet and Bill Goodson, and Christine and Paul Janicki) had flown in for the weekend. Dennis Landis was capturing the events and faces on film. (He had shown the old films, including some scenes from the superman play, on the previous night.) Alice and Skip Fuller had arranged for an open air clam and lobster bake (yes, a little different from hot dogs and hamburgers) and Fred Jones decided to set a record with these rather than with pies. John Hamilton, Don Burke, Bruce Smith and Joel Greenberger settled on the tennis court. The ex-dental group vicariously capped their experiences (Joel Schwartz, Dick Reisman, John Kelly). Larry Eron looked for Australian antigens in the bivalves while Robin Goodfellow lap'ed the lobsters. Larry Frisch appeared from Canada and Collins Lewis was readying to leave for South America. The rest of us just sedated ourselves while relating our experiences.

Although many were missing, twenty-three alumni and thirty-nine persons were able to be there and we found that the changes were not all that marked. The friendships had persisted in spite of the time elapsed and the ten year reunion should be something to look forward to with many more able to come.

**Paul D. Walter
Arlan Fuller
Dennis Landis**

Class Day 1976

After weeks of inclement weather, the 27th of May dawned sparkling. The white peaks of the tents and umbrellas gleamed above the green of the quadrangle as 153 members of the Class of 1976 and their guests arrived for the annual Class Day exercises. The graduating class — one-fifth of it female — actually numbered 158; five eager students had already received their degrees in March. After the speeches by members of the class — praised by Dean Ebert as “the best” he had heard in eleven years of Class Day programs — the special awards, prizes and honors were announced by Alvin F. Pous-saint, M.D., associate dean of students and director of student affairs.

Richard J. Cohen was the winner of the Henry Asbury Christian Award “to the student in the fourth year class who has displayed diligence and notable scholarship in his or her studies or research and offers promise for the fu-

ture,” for his paper entitled, “The Functional Relationship between the Polymerization and the Catalytic Activity of Beef Liver Glutamate Dehydrogenase.”

Mark C. Fishman received the Harold Lamport Biomedical Research Prize to the “student in the fourth year class who has demonstrated excellence and accomplishment in biomedical research entirely during the period when the candidate was a regularly matriculated student at Harvard Medical School” — and also the M.D. degree *magna cum laude* in a special field — for his paper, “The Membrane Potential of Juxtaglomerular Cells: A Central Role in Renin Secretion?”

Laura H. Glimcher was chosen as winner of the Soma Weiss Award for a paper, based on research, presented at the annual undergraduate assembly of the Harvard Medical Society — and also the M.D. degree *cum laude* in a

special field — for her thesis, “Identification of a New Cell Surface Antigen Selectively Expressed on the Natural Killer Cell.” Interestingly, Dr. Glimcher’s father, Melvin J. Glimcher ’50, won the same award for his research paper as a fourth year student sixteen years ago.

Laurie Rae Green was awarded the Richard C. Cabot Prize for a paper on “medical education or medical history, preferably of persons or incidents of the twentieth century,” for her “Study of Controversy in Twentieth Century Endocrinology: Walter B. Cannon and the Emergency Theory of Adrenin Secretion.”

Howard S. Magarian won the Rose Seegal Prize for a paper on the “relation of the medical profession to the community” for his paper entitled, “Developing Medical Care Programs in Highland Guatemala.”

George R. Merriam III was selected to receive the Leon Resnick Prize to the “fourth year student who has shown excellence and accomplishment in research conducted during his period of study at the Harvard Medical School” — as well as the M.D. degree *magna cum laude* in a special field — for his paper, “Enzymatic Methods for the Study of Catechol Estrogens and their Formation.”

R. Ted Steinbock, a third year student, was chosen as winner of the James Tolbert Shipley Prize for “research carried out by a medical student, the results of which have been published or accepted for publication,” for his book, *Paleopathological Diagnosis and Interpretation*, published by Charles C. Thomas, Springfield, Illinois.

Earnest Wu was awarded the Louise B. Carr Music Prize “to the student . . . contributing most to the general pleasure, relaxation and extracurricular fun of any or several segments of the medical school’s social life.”

Three more graduates, along with Drs. Fishman and Merriam, received the M.D. degree *magna cum laude* in a special field:

Robert R. Fenichel, for his thesis, “An Application-Independent Subsystem for Free-Text Analysis,”

Ronald N. Germain, for his thesis, “H2 Genetic Control of the Activity of Cytolytic T-Lymphocytes Stimulated by Trinitrophenyl-Conjugated Cells on Syngeneic and Allogeneic TNP-TARGET Cells,” and

Douglas C. Johnson, for his the-



After receiving all these prizes, the Class of 1976 revealed that it had a couple of its own awards up its collective sleeve. Class Day representative David W. Nierenberg summoned two surprised individuals to the podium. Miss Noreen A. Koller, who is “officially the registrar of the Medical School, but [whose] support and advice extend far beyond her job description,” was presented with an engraved plaque “in appreciation of her services far beyond the call of duty.” To Tom Wright, “soothsayer emeritus and resident sage” of Vanderbilt Hall, was given a plaque “in appreciation of his advice and friendship, freely given when most needed.”

sis, "Data Management Systems for Clinical Investigation and MEDINFO: a MEDical INFORMATION System."

Seven members of the class, besides Dr. Glimcher were awarded the M.D. degree *cum laude* in a special field:

Raymond D. Aller, for his thesis, "Development of Diagnosis Encoding, Retrieval, and Specimen Management Systems for Anatomic Pathology,"

Richard M. Fuchs, for his thesis, "A Characterization of the Effect of Dobutamine on Venous Capacity,"

Raymond J. Gibbons, for his thesis, "Distribution of an Inhaled Bolus from Residual Volume,"

Daniel B. Hrdy, for his thesis, "AEDES AEGYPTI and Dengue: Stain Susceptibilities and Life Histories,"

Craig W. Lillehei, for his thesis, "Stimulation of DNA Synthesis in BALB/C-3T3 Cells and Bovine Chondrocytes by a Cartilage-Derived Growth Factor,"

Bonnie Watts Ramsey, for her thesis, "The Effect of Acetylphenylhydrazine on Cation Permeability of Normal Human Erythrocytes," and

Lawrence C. Wolfe, for his thesis, "Red Blood Cell Membrane Phosphorylation: Studies in Normal and Hereditary Spherocytosis."

Membership in the national medical honor society, Alpha Omega Alpha, was accorded to twenty-nine of the graduates: Hugh Auchincloss, Jr., Beryl R. Benacerraf, Joseph V. Bonventre, Kenneth R. Bridges, Richard N. Clattenburg, Jr., Bradley W. Fenton, Mark C. Fishman, Roger A. Fleischman, Seth L. Garber, Phyllis I. Gardner, Raymond J. Gibbons, Laurie H. Glimcher, John E. Godine, Mark J. Greenwald, Gary L. Horowitz, Louis G. Lange, III, Craig W. Lillehei, Jean K. Matheson, David W. Nierenberg, Jane R. Parnes, Stephen J. Pfister, James A. Ramenofsky, Thomas H. Rossing, Mark S. Ruttum, Elaine Li Shiang, Brian R. Smith, Charles D. Swerdlow, Joel M. Weinberg, and Lawrence C. Wolfe.

This year's Class Day interlude of classical music — a tradition inaugurated at last year's ceremonies — was Mozart's Quartet in D Major for Strings, K. 575. The musicians were Daniel Chia-Sen Lee '76, violin; John Brown '79, violin; Yeou-Cheng Ma '77, viola; and Craig Hogan, Harvard College '76, violoncello.

Valediction

by Robert H. Ebert

"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way - in short, the period was so far like the present period, that some of the noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only."

There is a timelessness to that opening passage from *A Tale of Two Cities*, for it always seems to be the best of times and the worst of times and always the age of wisdom and the age of foolishness — particularly in an election year. But I do not intend to speak about the American political scene or the ever present international crises — but rather about medicine and what the future may hold for all of you.

How can I describe this as the best of times or the age of wisdom? I do so because of what I perceive as the ultimate fruit of this nation's investment in biomedical research. I had the privilege of serving as a member of the President's Biomedical Research Panel, which was asked to review the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. The panel commissioned a number of studies and among them a review by 160 distinguished scientists of the state-of-the-science in biology today. The verdict was that enormous advances have been made, and in the words of the panel report, "Readers of these re-



markable reports will sense the restrained elation of the authors who tell us that the success of the last three decades portend acceleration in the pace of discovery in the immediate and in the distant future." The group of scientists asked to review the fields of biochemistry, molecular genetics and cell biology noted that research to date had provided remarkable understanding of the organization and function of individual entities from macromolecules to cell organs. They further remarked that this phase of research was essential before it would be possible to elucidate fully the regulatory mechanisms that control cell function. Since much of disease has to do with abnormal behavior of regulatory functions, this next phase of research will contribute much more to the understanding of disease and its control. One can predict that in your lifetimes much of what is unknown about the causes of many diseases will be elucidated, and given that information it will be possible to approach rationally the prevention and cure of these plagues to mankind.

So, in a way, it has been the age of wisdom, for the federal government has supported liberally this major research effort. But it is also the age of foolishness, for there are those in the Congress who are saying stop all of this devotion to basic research and apply what you know. Give us some solutions to disease. This is foolish because one cannot apply partial knowledge to the solution of a particular disease. All of the necessary knowledge must be in place before it can be applied. The polio vaccine was possible only after it was known that viruses could be grown in tissue cultures of animal cells, that there were three and only three antigenic types of polio virus which remained antigenic after being killed and

that ample quantities of virus could be grown in tissue culture. No amount of money spent on a vaccine would have produced it until these facts were known. One cannot buy a cure to a disease, but one can support the fundamental work that will be required to find the cure at some future time.

Why should I call this the worst of times? There are many reasons, but I will choose our seeming inability to solve the problems of our health care system. Everyone today is aware of the maldistribution of physician services geographically and the apparent over-specialization of medicine. But I am more worried about the escalation of cost. Last year the health bill for the nation was 118 billion, and 250 billion is predicted for 1981. This rate of inflation cannot go on much longer without a collapse of the whole system, and therefore we can anticipate a variety of efforts to control costs. The most likely will be by regulation and you can anticipate a variety of measures via federal and state government which will attempt to put a ceiling on hospital costs, control the introduction of new patient services in hospitals and control the number of beds in a community. One cannot deny that regulation is needed, but medical care may be going in the direction of a public utility, and public utilities are not necessarily efficient nor cost effective. Economists such as Victor Fuchs and Alain Enthoven are anxious to build some incentives into the system so that both providers and consumers have some reason to control costs. They have suggested that there be more competition among providers so that different types of patient care organizations can evolve.

Ultimately solutions or at least partial solutions will be found to these problems of reorganization and financing, and whatever happens you will be needed. I view this as the best of times for you. Each of you is on the threshold of your professional career and each of you will contribute in your own way to the welfare of mankind. I take pride in you because you are what the Harvard Medical School is all about. Each of you is fully qualified for the next step in your professional education, and I know that each of you will more than fulfill our expectations - for me it is the spring of hope.

2001 -- a 25th reunion odyssey

by Francisco Moreszchki*

Alumni Day, Friday, falls on the 29th of May in the year 2001. It is a beautiful day but of course not quite as lovely as that transient bit of New England sunshine you enjoyed back on May 27, 1976. Many of you have returned for your twenty-fifth reunion, and I want to welcome you.



** The emigre White Russian professor is one of the few survivors of the Kolchak Rebellion. He made his way on foot across Siberia with a surgical instrument he was planning to bring to the United States. Recently, he has been made president of the Harvard Chamber of Commerce to raise money for the Quatrimillennial in 2026. By good fortune, this elder statesman was prevailed upon to present the twenty-fifth reunion address for the Class of 1976.*

I know you will be pleased to hear that the third year students, all sixty of them, will receive their M.D. degrees tomorrow. The physician assistants and nurse practitioners, 165 in number, were graduated last Thursday.

Maybe a word is needed about both. The third year students are now the graduating class, because the fourth year was abolished in 1980 following three lawsuits brought against the deans of the Harvard Medical School for curricular malpractice. The suits were brought because the students sought to recover their \$25,000 tuition for the fourth year, when they found that the elective year (already rather unstructured in your day, as you will recall) had been abolished. Absolutely nothing of a curricular nature was planned. One of the students stated, "I do not think we should pay to participate in a vacuum." In this graduating third year class, the Medical School is very pleased to announce that the enrollment of men is up to a total of eight or fully twelve per cent.

And as for the physician assistants and nurse practitioners, the federal government took over all the medical schools many years ago and stated that they would not pay for high priced doctors unless those same schools would educate some low priced doctors, too. After interminable arguments in the faculty, Harvard finally gave in. The first class was graduated in 1986, just ten years after you.

It was interesting that the same curricular exchange occurred at Harvard, that had been happening at Duke even back in your day. Namely, that the two curricula, one for physicians and one for physician assistants, showed some interesting contrasts. The medical cur-

riculum got smaller and smaller, shorter and shorter, with less and less science, fewer and fewer courses, no examinations, very little to do and finally abandonment of the fourth year. By contrast, the physician assistants' curriculum grew by leaps and bounds. Everyone enjoyed teaching these enthusiastic young men and women straight out of high school. It was a marvelous challenge. The faculty soon learned to teach them a tremendous amount of science and medicine. So Harvard set up a remarkable curriculum with lots of lectures, abundant laboratory work with didactic sessions, organized athletics (we beat Harvard College last fall!), many examinations, and lots of homework with a very rigorous system of grades. This curriculum was so good that it attracted the best men out of all the high schools of the country. Finally, in 1992, the two curricula crossed. It was noted in a small article on page 9 of *the New York Times* in 1995 that a nurse practitioner had employed two young women, recent graduates of this Medical School, to help him with his practice.

It is very easy to have two commencement exercises now in 2001. In fact, we could easily mount three of them, because the committee of medical deans was increased to three only last year. There is a story there, too. Back in 1977 your beloved Dean, Dr. Robert H. Ebert, stepped aside. President Derek C. Bok had a terrible job filling the post and finally had to appoint two people to fill his shoes. But the students still complained that they never saw the Dean! So Harvard appointed a third dean, specifically for the students to watch. He was dubbed the "Angel Dean" because the students could go up to see him any time.

Despite these local details, social advance has been very slow. Things have really not changed very much in the practice of medicine since you graduated in 1976.

You will recall that one of your Class Day speakers was an aging surgeon named Moore. The poor fellow died of a hangover after the New Year's Eve Party celebrating the year 2000. He had always said, "I can make it through to the end of the century if I can just live to be eighty-seven!" He and two of his classmates of the Class of 1939 — all

three of them ex-professors of surgery — were found just where they fell the next morning, with broad smiles on their faces. They had made it. Besides, one of them had just published a book on *Death with Dignity*.

Dr. Moore had stated at your graduation in 1976 that social change was slow but scientific change was rapid. To illustrate this point, Dr. Moore had used some examples from the previous forty years of his life, considering the period between 1936 and 1976. These years had included his own medical education and his period of active faculty membership. He pointed out that social changes had appeared to be massive because of several terrible wars. But actually they had accomplished little (except to save the world for democracy and then conquer fascism). In retrospect, these were very worthy causes but did not seem to have much effect on the practice of medicine. In addition, the wars had increased the supply of surgeons hugely.

After the second war, Blue Cross and Blue Shield had come in, originally regarded by the AMA as a communist conspiracy but later accepted. Voluntary health insurance became widespread but with very little impact on the conditions of practice. The government had entered the everyday practice of medicine through Medicare and Medicaid, but again with very little impact on the actual conditions of patient care.

By contrast, in those same years, 1936-1976, advances in science had been truly remarkable. The greatest medical discovery of the century, that of culturing polio virus with the development of vaccine and the disappearance of the terrible disease, occurred during a few mid-century years. This work had been done by Dr. John Enders with the help of two fourth year medical students, Robbins and Weller. They had done the work in buildings right within sight of us sitting here at the reunion, that have been designated as national historical sites. Jim Watson had cracked the genetic code and received the Nobel Prize in 1962. Now, in 2001, people are still working on it, trying to isolate new protein components and understand how the genetic code might be engineered. In 1987, all of this work had to go underground, and is for the

most part carried out in cellars, and in Mexico and the Philippines.

Antibiotics, initially considered to be a great advance, were finally banned by the FDA in 1999 because they were doing more harm than good.

Meanwhile, surgeons could proudly point to open heart surgery, which had brought relief to thousands of children with congenital heart disease and adults with valvular disease, and was beginning to make an impact on ischemic myocardial disease. Tissue transplantation was another surgical triumph that appeared quite suddenly about 1960 and so unexpectedly that it caught the experts unaware, one of whom had just published a statement that it could never be done. Unfortunately, both of these advances were later declared by Dr. Lewis Thomas of New York to be false technology and too expensive for general use. This drove many patients to Mexico and the Philippines. The remarkable restrictions on research imposed by the federal government had sent most of the research laboratories to these two locations and we note with sadness that most of our postgraduate scientific scholars are leaving the country at this time to study there.

Between 1976 and 2001, it has been much the same. There have been few social changes but remarkable scientific changes. Almost the only things of note on the social side have been the new National Health Insurance Act passed just seven years ago in 1994, and the terrible glut of doctors noticeable for the last twenty years.

As to the Health Insurance Act, the Junior Senator from Massachusetts, the Right Honorable Edward M. Kennedy, gradually became the Senior Senator from Massachusetts. Trying to pass some sort of National Health Insurance had become an obsession with him: a sort of Moby Dick. He tried and tried to get the legislation passed but with changing presidential administrations the political climate was never favorable. Finally, his son and two of his nephews passed the age of thirty and were legally eligible to be elected to the Senate. They came from several states but by 1994 it was possible to get the so-called Four Kennedys' Bill passed. Everyone was absolutely delighted.

It might seem surprising that everyone was happy about this. In point of fact, they were happy for various differing reasons. The government was delighted because the bureaucracy was doubled and a new building was required. It turned out to be slightly larger than the Pentagon. Practicing doctors liked the bill because they got paid for absolutely everything they did, rather than just almost everything they did. But most surprising was the American Medical Association. It was thrilled with the new legislation. To understand this, maybe a word is in order about the American Medical Association and its change since your day.

The AMA gradually got smaller and smaller over the years and by 1994 it only had 25,000 members, very few of whom spoke English. However, they had come to this country with high ideals to practice in America and earn a good living in the "good, old, free American system." They were thrilled with the National Health Insurance Act because they knew this would effectively block, possibly for another century, any substantial change in the organization or conditions of American medicine itself. It would pay for everything that was done, but all those things could be done in the same old way.

Now, as to the glut of doctors. This was due to two things: underproduction of people and overproduction of doctors. The population explosion simply fizzled out. It was sort of a flash in the pan. The birth control advocates had held up the specter of 300 million people in the United States by the year 2000, but actually there were only 250 million. The birth advocates claimed that they were responsible, but they could not discuss this very much because they were still having meetings to decide on the least toxic estrogen. The divorce lawyers stated that they were responsible for controlling population, while the Gay Liberationists claimed the credit for themselves: But whatever the cause, the growth of the country slowed way down.

By contrast, increased production of doctors went right ahead, as had been predicted by all the sociologists in 1976. By 1995, there were 450,000 doctors in active practice. This was to be contrasted with the 310,000 in practice in 1976; there was almost a forty per cent

increase in the doctor density — the number of doctors per million people. Many doctors were underemployed, still others were trying to go to the nurse practitioner schools and others were looking for good jobs in Mexico or the Philippines. Residencies had become extensively controlled.

When you graduated in 1976 you may not have realized it, but in that very month of May a new national commission had been formed, called "Geminac." Not many people knew about it but it was quietly going ahead with the matter of controlling residencies. The main object was to force young people to enter fields they did not wish to enter. This had the remarkable effect of producing anguish among medical students and reducing entrance into almost all fields except primary care, which had become temporarily fashionable twenty-five years ago.

By 1982, it was clear that a career in primary care was a myth, and that good medical care depended upon a balance between the family physician on the one hand and expert back-up consultant services on the other. Either one alone was a hazard. It turned out that small group practices proved to be the most effective way of giving family care. No one wanted to be called "primary care" because that meant that under law they always were required to call a consultant for a second opinion on everything. This led to the creation of a whole new set of "piggyback specialties." By this was meant that the individual said he was in a residency and later in practice in "primary care." This made him legal. It assured her of a good income from the government even during her residency. But then (in parentheses) he would indicate that she was doing cardiology, endocrinology, and even in some cases spilling over into obstetrics. A few might even have gone into surgery were it not for two other remarkable developments.

As to science — or rather biomedical engineering — the advances have been truly spectacular in these past twenty-five years. Surgeons, as you know, have become a vanishing species, because of the invention of the *Catcutter*, otherwise known as the *Surgisunderscooter*. This is a fully automated non-invasive surgical device de-

veloped on the principle of the Catscanner, but with the addition of high energy ultrasound to do the inside job. Back in 1976, the Catscanner was a prominent item. In fact, the *New England Journal of Medicine* published an article called "Cat Fever" concerned with the cost of these devices which, for a whole body model, was about \$500,000.

That expense was nothing at all compared with the cost of a Catcutter or Surgisunderscooter. These devices cost eight million each. The government decided that there should be only one in each of the nine census districts of the country. Back in 1976, as you will recall, everybody said that surgeons were underoccupied and that their work loads were too light. They did not carry out enough hernias or something equivalent to that; this point has always mixed me up. They were accused of being quite hypoactive in spite of the fact that they got up earlier in the morning, worked later at night and seemed to be more hectic than anyone else, probably just a personality defect. But in any event, the Catcutter did not make all that much difference except that the surgeons could now sit around a little bit more in the surgeons' lounges and possibly have a little more free time for golf.

The thing that really hurt was not the difference in work loads, but rather the fact that the Catcutter was soon taken over by Dr. Abrams and the department of radiology. Following his lead it was taken over by radiologists throughout the country. The specter, visualized back in 1976, became a reality. Radiologists finally dominated all of medicine and surgery and regarded all other physicians as their consultants. Occasionally, a radiologist might ask one of the old-time surgeons to come in and help a little bit if the Catcutter got out of order. And they might ask a physician or pediatrician just to give them a hand with the stethoscope if there was a little difficulty with the Catscanner.

Besides that, and causing a decline in surgery even before the development of the Catcutter, was the fact that cancer did not have to be removed any more because of a remarkable advance. This was the pesticide-induced mosquito mutant anti-tumor virus epidemic of 1984. It turned out that

some farmers in Southeastern Massachusetts were using a special pesticide in the cranberry bogs which had been especially processed by the FDA to be sure it did not cause cancer. A first year medical student, as part of his required clinical month, did a little research on this topic and discovered that in some of these populations there was no cancer whatsoever amongst either sex at any age, for almost ten years. Almost immediately it was shown that this was due to infection with a mosquito-born anti-tumor virus, and that the mosquitoes were a mutant form that had grown up because all the others had been killed by the pesticide. This remarkable discovery gave the Harvard School of Public Health a chance to return to its finest hour: fighting with the insect vectors of disease! The School of Public Health now had something to do, infecting mosquitoes and spreading them over the countryside.

Well, you are now at the mean age of fifty. Your class of 1976 is back for a reunion, but with remarkably few children. In fact, you have only 0.67 children per woman, a sort of fractional obstetrics that is quite difficult even for the Surgisounderscooter. But you have discovered that even those few children are quite rebellious. All of the children have agreed that the age of fifty is certainly a mean one. Curiously, it was noted that those members of the class who were most critical of medical school back in 1976 had the most rebellious children, most of them at a mean age of seventeen.

It is fun to look back. During your time there in the 1970s there were all sorts of conflicting purposes. The month that you graduated there was a simultaneous pair of demonstrations: one in New York by the "Right to Life" movement, and one in San Francisco on the "Right to Die." Actually, those two movements have gotten together with a sort of middle-aged spread, which, according to some, "ain't quite livin'."

Another curious feature of your time was that back there in 1972 you were amongst the lucky 14,000 admitted out of over 34,000 of your college classmates who applied to medical school. The unlucky 20,000 who could not get in were jealous of you. But soon all that changed. The tuition went up rapidly. It was soon obvious that there

were too many doctors, and about 1985 a remarkable thing happened. There was a sharp downward slope in medical school admission applications. All of a sudden there was little further need for so much medical education.* A total of forty of 116 medical schools in the country closed. Harvard's graduating class was reduced to sixty third year students, as mentioned above. The president, in secret, was thinking about firing one of his three deans.

The serenity of this Commencement and Class Day is largely due, not to the weather, or to peace in our time; it is due to a new Harvard Corporation rule passed in 1981. It is still in effect although many people have thought it unconstitutional and have declared it a form of thought control. The rule states very simply, "No member of the Medical Faculty shall publish an article critical of the Harvard Medical School, in the *New England Journal of Medicine*, within two weeks of Class Day." This remarkable rule was passed because of the continued storm centering on the Great Davis Incident of 1976. It was just too disturbing to have this sort of disquieting thing come up right at the time of Commencement. Members of the faculty are encouraged to have heterodox views and to voice them freely, but at other times of the year.

That incident finally blew over and is now nothing but a historical blur. One novel was written about it and then made into a movie, using it as a fine example of academic tempest of the late 1960-70 type, boiling up with a great storm of controversy over almost nothing. After all, none of the faculty felt critical of minority students, and everyone including the minorities agreed that the quota system was quite ridiculous for a major university. In any event, because of the incident and the rule, things are very serene here.

With Alumni Day of 2001 we greet you of the Class of 1976 and thank you for your generous gift of second-hand dinner china and those charming old Harvard plates, now out of print. Only a few of them are cracked and that makes them all the more interesting! Many, many thanks.

** I am indebted to Dr. J. G. Freymann for these interesting statistics.*

It is too bad that poor old Dr. Moore could not make it today. But even if he had he would not have been the oldest here. After all, Dr. Alexander H. Bill of Seattle, who was named president of the alumni association the day following your graduation in 1976 has made it here today and he is just fine. Welcome, Sandy. And even he would not have been the oldest, because after all, Bob Ebert is back. It is a delight to see him looking so sprightly at the age of eighty-eight and smoking his pipe as usual. Welcome, Bob.

Furthermore, some even older graduates have come back: Dr. Dunphy and Dr. Warren. They are both over ninety and they are here to get ready to celebrate their seventieth reunion. They are just as delightful as ever. The other night after a dinner party, Dr. Dunphy told one of his stories. When it was all over somebody raised her hand and said how much she enjoyed the story and stated that, "It was just as good as when I first heard it seventy-two years ago." Greetings, Bert and Rich.

It is too bad about Dr. Moore. He would have so enjoyed renewing friendships with the class that he had enjoyed knowing and teaching more than any other in his years at Harvard. After he resigned the Moseley Professorship back in 1976, he went right on teaching as the Cutler Professor and even gave a few lectures right up to that tragedy of the Great Hangover on New Year's Day, 2000. But he had always said, "There is nothing quite like that Bicentennial Year Class."

Ironically, now in 2001, everyone has forgotten about the Bicentennial. So much so that the Boston Chamber of Commerce and the Harvard Corporation have formed a new promotional committee to attract tourists to the 250th anniversary of our country. After all, that is only twenty-five years away in 2026 and it will coincide with your fiftieth reunion. We plan to recreate the battles of Lexington and Concord, sail "Old Ironsides" around, and have a brief moment of prayer in the Ether Dome. We will express our hope that the MGH can dig a hole for some new buildings and thus catch up with the Affiliated Hospitals Center. This national celebration will be known as the "Quatrimillennial." I hope you all can come.

Family practice

by Raymond D. Aller

Posterity will judge us not only by our positions, our patient care, and our publications, but also by our progeny.

As we have learned in the past two years of clerkships, care of patients can be very demanding of one's time. Our profession requires us to take care of the critically ill whenever they need it — not just at our convenience. As physicians, we will soon find that many other activities require time, including professional societies, continuing education, teaching and community responsibilities.

We became physicians to help others. We usually think about this in relation to caring for patients. However, for those of us with families, one of the most important legacies we will leave in the world, in the long run, will be our children. Unfortunately, physicians remember the needs of their patients, but sometimes neglect those of their children and families. Many a doctor's spouse is expected to patiently and cheerfully wait home while the physician spends sixteen hours a day in the hospital. Upon arrival home, he or she often approximates a zombie. Even those spending a mere eleven hours per day at the hospital are expected, by their peers and superiors, to devote much of their evenings to reading medical journals.

Small wonder then, that at a major Boston hospital, more than fifty per cent of the married interns have ended up separated or divorced. Physicians' wives have one of the highest rates of alcoholism of any occupational group. In a class at another medical school, ninety-five per cent of whom were married when they graduated, three-quarters were separated or divorced fifteen years later. Their children are often disturbed, or delinquent.



As human beings, and as citizens, our first responsibility should be to ensure that, if we choose to have a family, we raise that family well. I feel that one of the essential elements is spending sufficient time with them — which seems incompatible with the schedules of the training programs into which most of us are now headed. Children require time and attention from *both* parents to develop a healthy, stable personality. After being on thirty-six hours, what kind of parent can one be? To delay starting one's family for five more years, besides increasing the risk of Down's syndrome and maternal morbidity, will find the physician more firmly set than ever in the pattern of spending minimal time away from medicine.

This all paints a rather grim picture — how will our families survive the next few years, when such a schedule is the norm? I would like to suggest three approaches to the problem.

Do not just quietly accept a training schedule of 120 hours a week. You will not be in a position to change it directly, but at least you can make your feelings known. Work towards a night float, or other such system, so your families' time will not consist of watching you sleep after thirty-six hours on. If we paid heed to Larry Weed or Octo Barnett and instituted a new medical record technology to replace the current, two century old paper rec-

ord, it would ensure improved continuity of care, and eliminate any necessity for thirty-six hour shifts. In some hospitals, house staff work eight hour shifts. When the first residencies were established forty years ago, at such institutions as the Peter Bent Brigham Hospital, residents were not allowed to be married. The administrators were humane enough to realize that the schedule was *not* compatible with being a husband or father. Today, the schedules are lighter, but it is blithely assumed that residents should "grasswidow" their spouses and ignore their children for the sake of their medical training. It would be a lot easier to treat our patients like human beings if we could treat our own families more humanely.

Spend every moment you can with your family. Be creative about including your children in your professional life. In the bygone era when physicians made housecalls, they often took their children along. Make sure that all hobbies or activities are *shared* with them. Getting the backyard chores done may be less important than spending that time with your children. If you are already committed to eighty or one hundred hours a week at the hospital, is it really worth sacrificing time with your family for the monetary gain of moonlighting?

Appreciate the point of view of your spouse, who must sit home waiting. Do not demand that he or she stay at home every evening you have to work, or complain if dinner's not ready when you, for once, get home on time. If you are staying late to follow an interesting case, or to finish a mountain of work, remember that your time with your family is thereby reduced. Even though you have to listen to other people's problems all day, at day's end devote your particular attention to your own spouse and children.

This, then, is a plea for a method of training, and a style of practice, that allows the physician to be a responsible parent, and does not place the family as the lowest priority, to be fitted in after all other duties are fulfilled. The family represents a very important aspect of a human being's functions and activities. A life is successful and fulfilled — or the reverse — only when we have taken into consideration one's family relationships.

Our other patients

by Paul S. Appelbaum

You do not see many whole doctors anymore. We seem to be graduating them half-a-doctor at a time. That is not all bad, you understand. There is quite a bit that a piece of a doctor can do: diagnose a disease, deliver a baby and cut out a tumor, all the while training a piece of a medical student to be a piece of a doctor, too. Still, as you might expect, what we are getting from these fractions of doctors is a lot less than we could get from a whole.

The problem with a piece of a doctor is that in a world crying with need, he or she is only doing a piece — and a small piece — of the job. Trained in a system that defines the area of responsibility to include only those patients who present themselves at the office or hospital door, the partial doctor ignores the vastly larger number of other patients who need help as much — or more.

These other patients require a different kind of doctor, or maybe just a different piece, than the acutely ill or not-so-ill patients who dominate a daily practice. The poor in the slums need a doctor-politician. They need a doctor who, after a full day's work and not in place of it, can lobby for better lead-poisoning control programs, testifying, arguing and cajoling until the goal is won. The people in developing countries need a doctor-organizer. They need a physician who can plan a health care system for them and help them learn, and learn along with them, about the best way to use it. The oppressed around the world need a doctor-civil libertarian. They need someone to speak out, as a physician, against torture and injustice, and not rest until such practices cease. Throughout our country and our world are people who need a doctor who can



do something more than just give them a physical and a physic, and most of our doctors are simply not doing that part of the job.

Many, of course, will object and will say that a doctor's job is only to care for those who ask for help. The other tasks I have described they will see as the proper province of the lawyer, the public health expert or the professional do-gooder. They could not be more wrong. No voice is louder than the doctor's when health-related public programs are planned. No arm is as strong as the doctor's when it is raised against inhuman practices in this country or abroad. The doctor is obligated to do this, the other part of the job — for these, the other patients — precisely because he or she is the one who can do it best and may be the only one who can do it at all.

No doubt another objection has already come to mind: with the intense pressures of the practice of medicine today and the enormous workload of doctor and medical student alike, as much as one would like to fight for all these good, just things, there is simply no time to do so. The best way I can defeat that argument is to relate the story of the people with whom I have been privileged to work.

Three years ago, a small group of doctors, medical students and

other health professionals concerned with the situation of the Jews in the Soviet Union came together to discover if they, as members of the helping professions, could do anything to help. The doctors there were no less busy than other doctors, the medical students no less harassed. It would be wrong to say that they merely wanted to do something; it might be closer to the truth to say that they believed they had to.

Always approaching issues from the perspective of their profession, they outlined the most obvious ways they could help. Who could be a more effective advocate for a Soviet Jewish doctor, burdened by discrimination, yet denied permission to emigrate to the home of his people in Israel, than a colleague in America? Who could protest the abysmal health conditions in Soviet labor camps with more authority than a doctor who faces and treats each day the diseases which are there ignored? And when the Soviets use psychiatric facilities as prisons for Jews and other dissidents, who is more justly concerned than the psychiatrist whose profession is being degraded?

In the past three years those few doctors and medical students have grown into a five hundred member organization called the Medical Mobilization for Soviet Jewry. Similar groups have now formed around the country. The leaders of American medicine, many of them proudly faculty members of this medical school, have been enlisted in the fight. The Massachusetts Medical and Psychiatric Societies have taken the lead in condemning Soviet practices. Thousands of doctors have become aware of the plight of Soviet Jewish physicians, prisoners and psychiatric detainees and have moved to pressure the Soviet government to change their policies and correct their acts. And all of it, absolutely all of it, was done by students and physicians as short on time as any others. But, of course, they had no choice; they had to. They could not have faced themselves if they had not.

It really does not matter what the cause is. There are hundreds of battles waiting to be fought. The important thing to realize is that you are only a piece of a physician unless you are fighting one of them. You need those other patients as much as they need you. Only they can make you whole.

The seven warning signals

by Marvin J. Bittner

Much of the last two years of medical school is filled with clinical courses in which a medical student acts as a sort of apprentice doctor at a teaching hospital.

These clinical courses are quite different from the academic courses we have experienced in high school, college and the beginning of medical school. So there are a lot of surprises in them — a lot of pitfalls. While sulking after landing in some of these pitfalls, I have recognized seven warning signals of malignant aspects of clinical courses. I would like to share these seven warning signals with you.

The first warning signal is:
**HOARSENESS OR DIFFICULTY
SPEAKING — ON ROUNDS.**

When an HMSer's vocal cords
Sound like they're completely nailed
to boards.
It means all sorts of bad, bad things
on rounds.
Those little meetings that seem
to abound
Where students, housestaff, faculty
do meet
To talk of patients, teach,
and sometimes eat.

No roundsmanship for me —
That's what I thought it would be
When I started on clinical rounds
Buoyed by the hope that abounds.
No quoting from the *Journal of the
Royal College*
Simply to show off my medical
knowledge.

I wouldn't ask questions designed
Just to show off the facts in my mind.
I was very quiet on rounds.
Making very few sounds.
When that course was over and
through,
My evaluations said: You —
When it comes to your fund of
information,
You're in a nearly bankrupt situation.

So in my next inpatient rotation
I quoted without hesitation.
I quoted journals everywhere I could
And spoke up even when it did no good.
I didn't do much reading of the kind
That really adds to knowledge in my
mind.
But I sure took advantage of each
chance
To spout my knowledge, earn a friendly
glance.

For a uremic MGH denizen
I quoted *Annals of Internal Medicine*.
For a cardiac patient from Billerica
It was *Medical Clinics of North
America*.
A rutabaga grower came from Spain.
He had few white cells and some bad
joint pain.
When I could feel his spleen huge,
like a dome,
I shouted out: he's got Felty's
Syndrome!

Outdoing nearly every big textbook
I kept on blabbing out gobbledygook.
A group of red spots on a man from
Gloucester
Encouraged me to say that he had
zoster.
My rating sheets came back before too
long
Declaring that my knowledge was quite
strong.

From one course to the next, the set
of facts
That filled my head had barely changed
a crack.
The set of facts that spewed out of
my mouth —
That group had mushroomed, grown
without a doubt.
My teachers recognized not what I
knew
But rather what I could stand up
and spew.
And thus I learned that it's not
what you know:
The key in all the clinics is
what you show.



Rewards go to the well-rehearsed
presentation
And to the nicely chosen new quotation,
But not for thorough, thoughtful notes
in charts
Or careful minutes auscultating hearts.
And not for well-done patient interviews
Or talking to a patient, even two.
No credit goes for reading journals
that are bound
If you don't repeat all those facts
on rounds.

So when you're hoarse or not talking
on rounds.
Heed my warning ere trouble abounds.

That's one signal, one that's quite bad.
Now the other six signals I'd add
To warn you of by speaking in this
rhyme —
But I've already used up all my time.
Like much else in medical school,
Limits of time are the rule.
And six other signals are pending —
However, this speech is now ending.

Minorities at HMS: A promise turned sour?

by Fidel Davila, Jr.

It is with great reluctance that I address this topic on such a joyous occasion, but on May 13 similar articles appeared in the prestigious *New England Journal of Medicine* and the *New York Times* that did irreparable damage to the minority students of Harvard and of this nation. In a devious, irresponsible way these statements lead the public and some of the underinformed in the medical community to think that the minority students in the nation's medical schools have substandard medical qualifications and that this is adversely affecting their patients.

Strong statements by the informed and knowledgeable including the president of Harvard University, its medical dean, its medical faculty council and many other prestigious medical organizations have all taken issue with these articles and called them false — at the very least. But the damage has been done. Those of us whose skin is black or who have Spanish surnames have lost some public confidence and this has adversely effected our patient-doctor relationship. Now, in addition to the normal issues we must deal with, one more has been added — the irrelevant issue of one's ethnic heritage.

Needless to say, this is not new to us. I attended an elementary and junior high school that were over ninety-five per cent Chicano while the elementary schools and the other junior high across town were over ninety-five percent white. In high school, if the white advisors had had their way, I would have been in a vocational program like most other Chicanos they advised rather than in the accelerated college preparatory program like most of the whites they also advised. In my college job, I recall my supervisor maligning Chicanos to my face, not realizing I was one because my hair was not black or my complexion



dark. Also, if my college premedical advisor had had his way I would have dropped my medical school aspirations because I had received a 'C' in an honors English course — a language I did not learn until after starting school. Finally, just one incident typical of Harvard Medical School that occurred only three months ago: a research-oriented once-a-year attending physician questioned my minority status because I knew too much to be a minority student and this did not fit well with his preconceived ideas about us.

These are but a few of many similar incidents spanning the entire scope of daily living that have already occurred in one short lifetime. Unfortunately, these incidents have been very tame compared to what has happened to some of my black brothers and sisters, but they should not have occurred to anyone, regardless of ethnic heritage.

Now, as a result of these articles, old racial feelings have been stirred that will hamper our efforts to treat patients. These racial feelings will remain stirred for a long time, and it will take many months, even years, of extra work to overcome them.

In the meantime the attention of other medical schools who see Harvard as their standard will await the action taken against the author. I warn those faculty here today — if this action is not significant and appropriate for this major wrongdoing then it will be interpreted as assenting to the author's

premise even though your statement reads otherwise, since actions do speak louder than words. In fact, your inaction may very well encourage others within the University and outside it to make similar malicious attacks. Finally, if I present a picture of calm it is a false one. This incident has rekindled a great rage within me and if I do not show it, it is only from long experience.

The fifth wheel syndrome

by Samuel Z. Goldhaber

Medical school teaches us a new language of technical words, abbreviations and syndromes. Webster defines the word "syndrome" as "a group of signs and symptoms that occur together and characterize a particular abnormality." Some syndromes give credit to the first physicians to report the abnormality, such as the Wolff-Parkinson-White syndrome in cardiology. Other syndromes simply describe the abnormality such as "the respiratory distress syndrome of the newborn". I will now describe a group of dangerous signs and symptoms in a new medical syndrome.

When we enter the hospital wards after a year and a half of basic science, there is a disturbing vagueness about our role as medical students because our responsibilities are poorly defined. By the time we start our major medical ward rotation in the third year, the system has totally baffled us by not telling us what we are supposed to or allowed to do. Are we active participants or merely passive observers of the hospital course that patients go through? Most programs let us take histories and do physical examinations on the patients we follow. But rarely does anyone clarify how much leeway we have in planning a patient's diagnostic tests and treatment.

In Harvard's major teaching hospitals, patients are a scarce resource because there are so many doctors in training — chief residents, senior residents, junior

residents, interns and medical students. In this hierarchy the medical student is at the bottom and is therefore the first to be elbowed away. Making the medical student a passive hanger-on lowers the quality of medical school training, makes the M.D. degree itself less meaningful and ultimately adversely affects patient care. If medical students are ignored on the hospital wards, the training they deserve will only be postponed until the internship year. But by the internship year, new physicians should have accumulated the basic experience in patient management that the M.D. degree implies. Ultimately, patients benefit greatly from having experienced interns take care of them and this experience is properly gained in medical school, under careful supervision.



Patients can help students by providing them with a source of learning. But students can help patients, too, by contributing to their care. Occasionally it is the medical student who first elicits an important piece of historical information or notes a crucial physical finding that alters the course of hospitalization for the patient's benefit. For instance, I know a Harvard medical student who discovered a small malignant but curable skin cancer that several physicians missed. The medical student has an advantage of having more time to spend with a fewer number of patients than the busy intern or resident.

As medical students, we are justifiably frustrated. A University

of California at Davis medical student said, "In the university hospital, the medical student is the third person to examine a patient, after the resident and intern. Decisions are made before the student can make suggestions, and as a result his or her services are unused. This experience is humiliating for someone independent and self-reliant by nature with already two years of postgraduate education."

My own roommate became exasperated when he was the fifth medical person assigned to take a history and do a physical examination on a new coronary care unit patient. My roommate named the syndrome that is the topic of this talk. He called himself, "the ultimate in the fifth wheel syndrome." Like a fifth wheel, he had no responsibility in managing the patient he was examining. Like a fifth wheel, he was a passive observer rather than active participant in the patient's hospital course. Like a fifth wheel, he was ignored by everyone.

Dr. Howard Spiro of Yale would agree that the fifth wheel syndrome is a serious abnormality in medical education. As has written, "Something is wrong with the university hospital in which medical students are not given graded responsibility so that their decisions and suggestions can be treated with dignity."

The role and function of the doctor

by Nils M. Daulaire

I was fortunate enough to be able to spend my last half-year of Harvard Medical School away from Harvard Medical School. That may seem like an ungrateful thing to say to this institution that has nurtured and educated us, but I see it as similar to the case of the Vermont farmer, a devout and hardworking family man who every three years, like clockwork, would desert his wife and children, only to be found several

weeks later, drunk and disheveled, in a distant city brothel. Upon returning home he would resume his previous flawless behavior. No one said a thing about these repeated episodes until after the fifth time, when his minister decided it was time to have a talk with the farmer. "Ezekiel," said the minister, "you're a right enough God-fearing man two years out of three. What makes you run off like that?"

"Well, Reverend, the way I see it, God's doin' a right good job keepin' me home as much as he does. I just reckon he deserves a vacation from watching over me every now and then. Besides, around here, I can't hardly see the sins he protectin' me from."

In the three months that I spent in a rural health center in Bangladesh this spring, I discovered there are a great many more sins in this world than we learn about at Harvard. After three and a half years here, I went well-armed against cardiomyopathies, lupus erythematosus and Landry-Guillaime-Barre syndrome. I knew I would have to work without a CAT-scan, but was not really sure how I would manage. What I found was not an array of fascinating medical "problems" lined up awaiting only the proper scientific clinical approach. What I found can perhaps best be illustrated by an entry from the diary I kept while I was there:

March 12. At the outdoor clinic in Shimulia today the usual line of fifty to sixty peasant women is waiting for us. They are all without shoes and clad only in their rough cotton saris, probably the only clothes they own. Most are holding or shepherding one or more children, and even in the outdoors the noise is tremendous.

A glance tells me that more than three-quarters of the children have severe scabies; some are covered with pus-filled sores and don't even bother to shoo away the flies that cluster thickly on them.

A woman squats at the front of the line, her brown face deeply furrowed. A baby only a few months old feeds from her sagging breast, and she holds another child out to us. He is Roshid, two years old. He weighs perhaps five

kilos. His eyes are sunken, his skin is dry, and his mother tells us he has had severe diarrhea for the past two days. Following time-honored tradition, she has given him no food or drink in that time so as not to "feed" the diarrhea.

His pulse is rapid and weak, and he doesn't even move when I examine him. It's obvious that he needs immediate rehydration, and I offer to take him to our small hospital. She balks. Couldn't I just give him an injection? I tell her that won't help, that it's really important for the child that he come with us. She still refuses; she is too poor, she says. I tell her we will not charge her. She carries on a rapid conversation with the paramedic I'm working with, who explains to me that the woman cannot leave her four other children to attend to this one in the hospital. Her husband works twelve hours a day in a landowner's paddy-field for which he gets half the rice he is able to grow, and he cannot afford to stop for even one day to watch the children while she is away.

I do my best to convince her, but it's useless. To her, a hospital is a place of death, and in the end I can only offer oral rehydration fluid and advice on feeding. I can read her feelings clearly on her face — her disappointment that this foreign doctor cannot provide the miracle cure, her resignation to the realities of life . . . and death. She leaves, carrying Roshid, his baby sister and several packets of our electrolyte mixture.

For the hundredth time frustrated and furious, I turn to the paramedic. "Why can't these people at least space their children? Then, with longer breastfeeding, at least they'll be better nourished and more disease resistant."

The paramedic answers patiently. "This woman is very poor. She and her husband know they need sons to support them when they are old. She has had fourteen children, only five are alive now. Roshid is the only boy. They won't accept any sort of family planning unless they can be guaranteed surviving sons. We can't promise that."

I know that she is right, and I also know that tomorrow there will only be four children left in this family, and they will be without a son once again.



As in most of the cases I saw, the medical solutions here were quite straightforward. It is the economic and societal factors that make them so difficult. In Bangladesh, hundreds of thousands of people, most of them children, die needlessly every year. Millions more balance on the razor's edge. As physicians, what is our response to be to this situation? Will we join with the proponents of the so-called "lifeboat" approach who insist on an end to all assistance to those countries unable to control their populations, while we continue conducting our costly research into rare and esoteric diseases?

What will the result of that be? The underdeveloped countries will not respond to "benign neglect" by conventionally shriveling up and going away. Rather, they will reach a steady state: a high birth rate, balanced by a high death rate. Are we ready to let half the world live in misery and degradation, pockets of teeming unrest and political instability ready to explode across the face of the globe, while we lecture them about their responsibility to control their growth? Or will we step up our efforts to assist these countries in solving their problems?

Like the Vermont farmer, I have returned home with something of a hangover and a view of the outside world I will never be able to erase. In Bangladesh I saw firsthand some of the major health problems facing the world today. At Harvard I had never learned to deal with them, in fact I hardly had

been exposed to them. I found myself sadly lacking in training and experience, but I learned something there that was tremendously valuable: the problems of the underdeveloped world are not insoluble. To be solved, though, they call for serious commitments on the part of governments, institutions and individuals.

As the profession that can perhaps contribute the most, our responsibility is the heaviest. The real question is: are we willing to accept it.

A way of life

by Earnest Wu

When we came to Harvard Medical School, we were stepping into another world. In a sense, we divested ourselves of our worldly habits to lead a monastic existence of books and journals. We traded a period of purpose: a remaking of the world, which preoccupied us during our college years, for the sole determination to become a physician. But the tools for such a creation were left to our own endeavors. As a result, that single purpose sometimes wavered and even shook.

Though our experiences are highly individual, there is, nevertheless, a common base of frustration, disillusionment and cynicism. To be sure, there have been moments of great achievement: new understanding, new insight, the realization of one more difficult step in becoming a physician, worth the price of the rarest of gems. Whether the outcome will be worth the groping for role models, the struggle to distill facts from a mountain of opinion, the lonely questioning of our mortality — the anguish each of us felt in the four years of relative neglect — is a question to be judged by time.

Now we must reemerge from this cloistered world and don worldly habits of even greater responsibility. We must define, once again, a purpose, or a set

of principles, or even rekindle the spirit that made us activists. In short, we shall have to establish a *way of life* that will comfortably unite our ideals and our wants and that will effect some small change to make a more habitable world. In this spirit, I wish to share a few thoughts with you, which should always be kept in mind.

No man or woman has ever been born with knowledge or wisdom, in medicine, or in anything else. From nothing we learn; we build; and we discard. At best, we capture a glimpse of the greater truth. What we know is the best that we can get with our best endeavors. For this we can never, and should never, be faulted. Unless at the outset the limitations of our human faculties are accepted by us and others, nothing but misery and disappointment await us.

Realize that knowledge and wisdom are not one and the same. Sir William Osler pointedly admonished young house officers that "it is a common error to think that the more a doctor sees the greater his experience and the more he knows." We ought to learn from our cases to extract the essential relationship of disease and patient, and integrate it into the essence of mind and heart in each of us. This is the germinating seed of wisdom. One more case that squanders rare and invaluable free time — which would be better spent in limbering mind and body, in thought and in seeing the world so that, according to Osler, "we may be better men [and women] for it and certainly not worse practitioners" — will not add to our overall skill as physicians.



Remember that there are two halves within us: a mind and a heart. We should always temper the mind with the heart. The mind poorly equipped with the analytic tools and standards of "other men," tends to be cool and judgmental, even in the best of motives. The heart, possessing some vague imprint of a greater wisdom, tends to be merciful and understanding.

Earlier, I implied that the Class of '76 has the particular distinction of being amongst the last of that set of concerned college graduates who had agitated for change, who called for the renewal of ideals grotesquely twisted by generations of public neglect and avarice. We even carried that torch through our first two years of medical school. How may we keep this spirit alive? As the ancient Chinese philosopher Lao-tsu said, ages ago:

Fame or self: which matters more?
Self or wealth: which is more precious?
Gain or loss: which is more painful?
He who is attached to things will suffer much;
He who saves will suffer heavy loss.

Perhaps, by being more selfless, by upholding our ideals, by clutching our visions of a better world, we can keep the torch lit.

It is said that though mankind is advancing, man is always the same. Love, hope, fear, faith, which make humanity and the passions of the human heart, remain unchanged. The secret inspiration of any art form is the capacity to touch the chord that vibrates in sympathy with each and every heart, that knows not time or place. Medicine, at its core, underneath layers upon layers of scientific trappings, is an art, to be practiced and developed with growing wisdom.

These are only a few thoughts I wanted to share with you, to give ourselves some direction in the future and to remove the scars of cynicism and callousness won in four years of emotional and intellectual battle. I wish us all the greatest luck.



Scenes from Class Day '76

We saved the best (visually, that is) for last. The rewards of Class Day will be savored for many years to come by HMS '76, family and friends, except for this baby (top), who was preoccupied. Below, Dr. David Freiman, Mallinckrodt Professor of Pathology (right), and Mr. Henry Meadow, senior associate dean for administration, approve of the sentiments of the day. Left, roses and applause bring a smile to the face of quartet member Yeou-Cheng Ma '77.



Letters

Do we have style?

I am a firm believer in style. Your *Bulletin* lacks style. From a typographic standpoint, it is so drab, so soporific — it's abominable. Yet, your material is exciting and original and fresh.

I have complained before. I have promised myself that I will complain again. Why not walk down the street to the *New England Journal of Medicine* and see how they do it? It's not the *best* format in the world but it's light-years ahead of yours. Please let me read the *Bulletin* with pleasure. Please get up some style.

Edward H. Ahrens, Jr. '41

The bicentennial issue of the *Bulletin* is fabulous! Believe me, I speak with both knowledge and feeling, for I spent many months preparing a comparable bicentennial issue of *JAMA*, for July 5, 1976. I know intimately the problems involved — finding a central theme, approaching and persuading your authors, holding to deadlines, and editing the papers into a unified whole. You did a splendid job and deserve the heartiest congratulations for an important historical contribution.

Of all the commemorative numbers of innumerable journals that will appear this year, I think this issue of the *Bulletin* will prove to be number one in merit.

Lester S. King '32

The conception was brilliant, and the execution is stunning. I am extremely delighted with both the substance and the appearance of your brain child, which just reached me yesterday. So far as I have read, I consider myself proud to appear in such company. And the way the text and the pictures were interwoven makes for an unusually attractive format. You are to be highly congratulated, and I trust that you will receive the acclaim that you deserve.

I do notice that, on the page opposite the biographical information about the contributors, Neale Watson announces publication of the book version of these articles. That is very good news to see, especially appropriate since it points out to readers how they might secure the contents of a journal in a cloth bound volume.

It has been a joy to work with you on the Signers project, and the result is so outstanding that it has made me deeply pleased. Thank you again for asking me to participate.

James Harvey Young

I wanted to congratulate you on the latest edition of your alumni magazine in which you assembled such a fine collection of articles by distinguished historians. Anyone at all interested in medical history would find the issue useful and informative, and I am well aware how difficult it is to plan and put together an issue of such substance. I should add, too, that both my editor and I feel the book is a handsome design piece as well.

As we in Philadelphia prepare for the summer onslaught of the plastic Liberty Bell set, it is somewhat comforting and redemptive that the bicentennial has been the impetus to something more than the excesses of the marketplace. And yours is a publication I'd like to save.

(Mrs.) Joy Roff Mara
Assistant Editor, Alumni Bulletin
Jefferson Medical College

I have read most of the articles on the five physician signers of the Declaration of Independence and have thoroughly enjoyed them, as well as improving my knowledge concerning the two Connecticut-born physicians. May I compliment you on the selection of this timely subject as well as on the choice of the authors. I would like to have copies to present one each to the Hartford Medical Society, the Hartford Hospital House Officers Library and the University of Connecticut Medical School Library. The former two libraries and the librarians would very much ap-

preciate having a copy for their permanent records. I well believe that the articles should be read by physicians other than Harvard graduates.

E. Myles Standish '22

To whom

It has been said, "If you hear an owl hoot *To whom* instead of *To who* you can make up your mind he was born and educated in Boston." Ralph Waldo Emerson complained, "We are students of words: we are shut up in schools and colleges for ten or fifteen years, and come out at last with a bag of wind, a memory of words, and do not know a thing."

The day when these calumnies held a grain of truth is past, as the graduates who attended the quinquennial reunions in May had an opportunity of learning. No one can truthfully say that the speeches made on that occasion were windy or gave evidence of any lack of knowledge of the subjects under discussion. What has apparently been lost is the memory of words; it was obvious that the speakers merely lacked that quality which once made the Boston owl recognizable. *Cum sint populares multi varrique lapsus* (Cicero).

The very word *alumnus* seemed to puzzle most of the speakers; it was variously pronounced *aloom-nye* or *alumni-nee* (never *aloom-nee* or *alum-nye*), and one speaker sought vainly for the plural form of what he seemed to think was a singular noun (just as *media* has popularly become a singular form). One orator was guilty of the common error of pronouncing *status* as if spelled *stattus*; another used *fortuitous* in the sense of *lucky*; another fell into the African pronunciation of *haráss-ment*, innocent of the proper Bostonian *hár-assment*.

It is ungracious to pick nits, but it is also disturbing to observe them in the hair of an otherwise carefully coiffured fellow person. One cannot help wishing to listen once again to the admirable accents of a Franklin Dexter, a David Cheever, or a Robert M. Green.

Robert W. Buck '21

Name-calling

This is in response to C. David London ('71)'s letter in the May-June issue. I was introduced to Mr. Andrew Napetcha by his first name and always referred to him by it in his presence. I never knew his last name until I was informed by Dr. London in his letter. I spent many interesting and quite educational hours with Mr. Andrew Napetcha and had the utmost respect for him. He taught me a great deal about the Zuni culture and was very influential in my endeavors to help organize an alcoholic center in Zuni. Therefore, I referred to Mr. Andrew Napetcha by his first name in my article because that was the only name I knew him by, personally.

I hope the next time Dr. London is confronted with an article that contains details he is disturbed by, that he will con-

tact the author personally or write a letter in a respectable way, and not full of vindictive, slanderous and erroneous accusations as he did in the May-June issue.

Leonard Nelson '76

Indian elective unique

I would like to disagree with John Stoeckle a bit regarding the uniqueness of the Zuni elective that was described in the January/February *Bulletin*. My perspective includes a three month elective as a medical student in the community medicine department of the Massachusetts General Hospital where I studied health care in Charlestown, two years in the Indian Health Service, a month as preceptor in Zuni and a month spent precepting a student in my practice as part of the Harvard Family Practice preceptor program.

I learned three things during my experiences in the Indian Health Service which were unique to that experience. First, it is impossible to ignore the role of culture in health because the differences between Anglo and Indian culture are so vast. Second, the great distances in the West mean that areas are quite isolated from each other and therefore patterns of care, disease incidence, etc. are often easier to appreciate. Third, the responsibilities of the Indian Health Service for health care are very broad, encompassing hospital and ambulatory curative services, health education, school health, environmental health and public health nursing for a start. At any local elective, these functions are divided among many organizations.

While I think local "remote site" electives are valuable and I will continue to work in such a program, I also feel that the Zuni elective has special values which should not be overlooked.

Karl Singer '67

